PATIENT OR FAMILY: PLEASE COMPLETE THE SHADED AREAS (TOP and LEFT)

Name ____________________ DOB________ Medications (Rescue) _________________________(Control)____________________________

Provider___________ Date _________ Asthma Triggers: Infections/colds ☐ Allergies ☐ Weather ☐ Activity ☐ Other______________

During **the past 4 weeks** how often was your child bothered by breathing problems, such as wheezing, coughing or shortness of breath?

☐ Not at all ☐ Once or twice ☐ Once every week ☐ 2 or 3 times per week ☐ 4 or more times a week

During the **past 4 weeks** how often did your child's breathing problems (wheezing, coughing, shortness of breath) wake him or her up at night?

☐ Not at all ☐ Once or twice ☐ Once every week ☐ 2 or 3 times per week ☐ 4 or more times a week

During **the past 4 weeks** to what extent did your child's breathing problems such as wheezing, coughing, or shortness of breath, interfere with his or her ability to play, go to school, or engage in activities that a child should be doing at his or her age?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a lot ☐ Extremely

During the **past three months** how often did you need to treat your child's breathing problems (wheezing, coughing, shortness of breath) with quick relief medication? (Albuterol, Ventolin, Proventil, ProAir or Xopenex).

☐ Not at all ☐ Once or twice ☐ Once every week ☐ 2 or 3 times per week ☐ 4 or more times a week

During the **past twelve months** how often did your child need corticosteroids (Prednisone, Prednisolone, Orapred, Prelone, or Decadron) for breathing problems not controlled by other medications?

☐ Never ☐ Once ☐ Twice ☐ 3 times ☐ 4 or more times

(20) (15) (10) (5) (0)

Score < 80, review control medications

Severity: ☐ Intermittent ☐ Mild Per. ☐ Mod. Per. ☐ Severe Per.

PROVIDER COMPLETE AND GIVE TO PATIENT/FAMILY:

Updated asthma assessment:

___**Under Control** ____ **Not Controlled**

____ Maintain ____Step Up

____ Step down ____Other____________________

Medication or other changes today:

____

____

Referrals/other: ____

Follow-up visit: ________________ **Recommended Flu shot:** YES NO

What is "good control" of asthma?

No asthma symptoms with activity, daytime symptoms less than 2 times per week, night symptoms less than 2 nights a month and no need for steroids, ER or Hospital visits.

How do you know when to use rescue medication, such as albuterol?

Safe Zone Breathing is good, no cough or wheeze, can work/play without breathing problems. No rescue medicine needed except if before exercise. **Plan**: Use controller medication every day (if prescribed).

Instructions: ____

Caution Zone Having some problems, cough or wheeze, tight chest, waking at night. **Plan**: Start rescue medication and continue controller. If no improvement call our office.

Instructions:____

Danger Zone Having a lot of problems breathing, breathing hard and fast, can't walk or talk. **Plan:** Give rescue medicine immediately and call the office now (day or night) or go to the Emergency Room if unable to reach us.

Instructions:____