UCLA Health

MRN:

Patient Name:

PEDIATRIC ASTHMA CONTROL AND COMMUNICATION INSTRUMENT

Department of Pediatric Pulmonology & Sleep Medicine

Please mark one answer for each.. Your answers will help your doctor give the best asthma care. Asthma includes “reactive airway disease,” regular coughing, wheezing, or difficulty breathing with and without colds.

When was the last visit to this clinic for asthma? ______________ If never, check here ☐

Since your child's last visit to this doctor's office:	**Direction**		
**If none, please answer for the last 2 months.	Better	Same	Worse
1. How has your child's asthma been?	☐	☐	☐

Since your child's last visit to this doctor's office:	**Bothered**		
**If none, please answer for the last 2 months.	Not bothered	Somewhat bothered	Very bothered
2. How much have you been bothered by your child's asthma?	☐	☐	☐

Since your child's last visit to this doctor's office, has your child: **If none, please answer for the last 2 months.	**Risk**	
	Yes	**No**
3. Been to the emergency room for asthma	☐	☐
4. Been hospitalized for asthma?	☐	☐
5. Used Prednisone (Orapred, steroid pills, steroid liquid or steroid syrup) for asthma?	☐	☐

Forget to Take Medicine	My child is not supposed to take daily asthma medicine	None of the time	Some of the time 1-2 days/ week	Most of the time 3-4 days/ week	All of the time 5-7 days/ week
6. How often do you forget to give your child **daily** asthma medicine when he/she feels fine? Examples: *Advair, Alvesco, Asmanex, Budesonide, Dulera, Flovent QVAR, Pulmicort, Singulair, Symbicort, etc.*	☐	☐	☐	☐	☐

FOR CLINICAL USE: If any of the answers in red ☐ are selected, this may be consistent with poorly controlled and/or undertreated symptoms. Further assessment and follow –up in 2-6 weeks is recommended

These questions are about your child's **recent** asthma symptoms:

Current Asthma Symptoms	**Days**				
	0	1-2	3-6	Every day (not all day long)	Every day (all day long)
7. Over the **past week**, how many days has your child had asthma symptoms? e.g., *Cough *Tight Chest *Short of breath *Sputum (spit, mucus, phlegm with cough) *Difficulty taking a deep breath *Wheezy or whistling sound in the chest	☐	☐	☐	☐	☐

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Reliever Use	**Days**				
8. Over the **past week**, how many days have you had to give your child medicine to quickly relieve asthma symptoms? (e.g., Albuterol, Proventil, ProAir, Ventolin, Xopenex)	0	1-2	3-6	Every day (not all day long)	Every day (all day long)
	☐	☐	☐	☐	☐

Attacks	**Days**			
9. Over the **past week**, how many days did your child have an asthma "attack"? (e.g., *Hard to breathe *Gave more quick-relief asthma medicine (e.g., Albuterol) *Asthma medicine did not work	0	1	2-3	4-7
	☐	☐	☐	☐

Activity Limitation					
10. Over the **past week**, how much has asthma symptoms limited your child's activities?	None	Slightly	Moderately	Very	Completely
	☐	☐	☐	☐	☐

Night Symptoms					
11. Over the past **TWO WEEKS**, how many nights did your child's asthma keep your child from sleeping or woke him/her up?	0	1	2	3-7	8-14
	☐	☐	☐	☐	☐

12. Please write any concerns would like your doctor to know about your child's asthma:

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FOR CLINICAL USE ONLY CONTROL/SEVERITY ASSIGNMENT	**Sub-Acute Severity/Control Classification**			
Assign patient's current level of control by looking at the box checked farthest to the right on questions 7-11 and match the box color to the level of control in this selection.	☐	☐	☐	☐
	Controlled/ Intermittent	Partially controlled/ Mild Persistent	Uncontrolled/ Moderate	Poorly Controlled/ Severe

Patient or Representative Signature ____________ Date ____________ Time ____________

If signed by someone other than the patient, please specify relationship to patient: ____________

Interpreter Signature ____________ Date ____________ Time ____________

Interpreter ID # ____________