Pediatric/Adolescent Asthma Therapy Assessment Questionnaire

Patient Name:_____

ID Number:_____

Physician Name:_____ Date:_____

Please have the parent or guardian complete this questionnaire.

INSTRUCTIONS: Check 1 answer to each question and enter point value (0 or 1) on line

	Control Issues	Other Issues

1. In the *past 4 weeks,* did your child:

a) Have wheezing or difficulty breathing when exercising?	☐ Yes (1)	☐ No (0)	☐ Unsure (1)	____
b) Have wheezing during the day when **not** exercising?	☐ Yes (1)	☐ No (0)	☐ Unsure (1)	____
c) Wake up at night with wheezing or difficulty breathing?	☐ Yes (1)	☐ No (0)	☐ Unsure (1)	____
d) Miss days of school because of his/her asthma?	☐ Yes (1)	☐ No (0)	☐ Unsure (1)	____
e) Miss any daily activities (such as playing, going to a friend's house, or any family activity) because of asthma?	☐ Yes (1)	☐ No (0)	☐ Unsure (1)	____

2. Does your child use an inhaler or a nebulizer for *quick relief* from asthma symptoms?* ☐ Yes ☐ No ☐ Unsure

(If Yes) In the **past 4 weeks**, what was the **greatest number of times** in 1 day your child used this inhaler/nebulizer?

0	☐ (0)	5 to 6	☐ (1)
1 to 2	☐ (0)	More than 6	☐ (1)
3 to 4	☐ (1)*	**Enter score** →	____

3. Has your child ever had a prescription for an asthma medicine that is NOT used for quick relief but is used to *control* his/her asthma? ☐ Yes ☐ No ☐ Unsure

(If Yes or Unsure) What best describes how your child takes this medicine now?

Takes it every day	☐ (0)	Only takes it when he/she has symptoms	☐ (1)
Takes it some days, but not other days	☐ (1)	Never takes it	☐ (1)
Used to take it, but now does not	☐ (1)	**Enter score** →	____

4. Are you dissatisfied with any part of your child's *current* asthma treatment? ☐ Yes (1) ☐ No (0) ☐ Unsure (1) ____

5. Do you believe that:

a) Your child's asthma was well controlled in the **past 4 weeks**?	☐ Yes (0)	☐ No (1)	☐ Unsure (1)	____
b) Your child is able to take his/her asthma medicine(s) as directed?	☐ Yes (0)	☐ No (1)	☐ Unsure (1)	____
c) Your child's medicine(s) is useful for controlling his/her asthma?	☐ Yes (0)	☐ No (1)	☐ Unsure (1)	____

6. During this office visit, would you like the doctor to discuss:

a) Different types of drugs available to control asthma?	☐ (1)	
b) Your child's asthma treatment options?	☐ (1)	
c) How your child prefers to take his/her asthma medicine(s)?	☐ (1)	
d) Other issues?	☐ (1)	
	Enter score →	____

Add numbers in the light blue area and enter total SCORE here. **TOTAL** → ____

Add numbers in the dark blue area and enter total SCORE here. **TOTAL** → ____

If either SCORE is 1 or greater, discuss questionnaire with your doctor.

*This reflects a lower threshold to identify potential control problems than was used in the ATAQ validation studies. This modification was designed to encourage patients and providers to discuss how asthma medications are being used.

20605031(3)-10/06-SNG-MCM Printed in USA. Minimum 10% Recycled Paper