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.

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.

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 __________

   *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.