Paint Creek Pediatrics
200 Diversion Street, Ste 20
Rochester, MI 48307
(248) 656-3440

ASTHMA CONTROL TEST

Patient Name: _____ DOB_____

How is your asthma today? □ Very good □ Good □ Bad □Very Bad

Over the last four weeks:

How often do you cough and/or wheeze?
□ 0-2 day/wk □3-6 days/wk □ Every day □ More than once a day

How often do you wake up because of your asthma?
□ 0-2 nights/month □3-6 nights/month □ More than once a week □ Nightly

How much does your asthma interfere with your activity?
□ None □ A little □ Some □ A lot

How often do you need to use Albuterol?
□ 0-2 days/ week □3-6 days/week □ Every day □ More than once a day

Do you check peak flows? □ Yes □ No

What is your peak flow over the past few weeks? _____

How many courses of Orapred/Prednisone/Prelone have you taken this year? _____

Does anyone in the home smoke? □ Yes □ No

Do you have any known environmental allergies? □ Yes □ No

If yes, then to what? _____

Have you been ill because of anything other than asthma during the past few weeks?
_____

Please list dates of ER/Urgent Care/ hospital visits because of asthma during the past year.
_____

_____

Please list current medications.
_____

_____ _____
PARENT SIGNATURE DATE