Today's Date:_____

Patient Name: | FMP and Sponsor SSN last four: | Contract Number: Date of Birth:

ASTHMA VISIT

Do you have any specific concerns today?_____

Are your child's asthma symptoms stable, improved, or worsening? _____

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents)	Medications (PLEASE INCLUDE DOSAGE)
Hayfever/ADHD/Chronic Ear Infections/Other:		Hayfever/Allergies Other:	(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):

Please list any known allergies your child has (drug, food, latex)_____ ☐ No Allergies

Are your child's immunizations up to date? ☐ Yes ☐ No

Who does the child live with? _____

Does your child attend: ☐ Day care ☐ Public/ Private school ☐ Home- Schooled (Grade:_____)

Does anyone in the family smoke or is your child exposed to secondhand smoke? ☐ Yes ☐ No

Do you & and your child feel safe at home? ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Other:_____

What is your preferred method of learning: ☐ Verbal ☐ Written ☐ Visual ☐ Other: _____

Are there any cultural or religious considerations that may affect your child's healthcare? ☐ Yes ☐ No _____

Is your child enrolled in the Exceptional Family Member Program (EFMP/ Q-coded)? ☐ Yes ☐ No

Is the child's sponsor currently deployed? ☐ Yes ☐ No

Is this visit deployment related? ☐ Yes ☐ No

In the past month, has your child had any of the following due to their asthma?

	Yes/No	Frequency
Exercise limited by asthma?		
Missed school?		
Wheezing?		
Wheezing with a cold?		
Cough with exercise?		
Cough at night?		

	Yes/No	Frequency
Daytime cough?		
Runny nose?		
Nasal congestion?		
Trouble breathing?		
Other:		

Circle if your child has/had: Born Preterm/ Eczema/ Bronchiolitis/ Pneumonia/ Reflux

When was your child diagnosed with asthma?_____

Circle what triggers his/her asthma? Exercise/Common cold/Tobacco smoke/Cold weather/Hayfever/Allergies/Other:_____

How many times has your child been hospitalized for asthma in the past 5 years?_____

Has your child ever been admitted to the PICU? ☐ Yes ☐ No **If "yes", have they ever been intubated?** ☐ Yes ☐ No

How many times has your child been seen in the Emergency Department in the past year for asthma?_____

How many times has your child taken oral steroids (Prelone/Prednisone) in the past year?_____

When was the last time your child used Albuterol or Xopenex?_____

If your child is over 5 years old, have they had pulmonary function testing? ☐ Yes ☐ No **When?**_____

Does your child have an asthma action plan? ☐ Yes ☐ No

Has your child had a flu shot this season? ☐ Yes ☐ No

Today's Date:_____

HT		**BP**		**Pain:** □ Yes □ No **Location of Pain** _____
WT		**HR**		
Temp		**RR**		
		SPO2		**Immunizations UTD per AFCITA:** □Yes □No **Technician Signature:**_____

*Other VS per Provider request

HPI:

N E	Examination:	Normal	Abnormal
□	**General:**	□ Active/Alert/WN/WD/NAD/ not dysmorphic	□
□	**Head/Neck:**	□ NCAT/Nontender/FROM	□
□	**Eyes:**	□ RR X2, nl corneal reflex, EOMI, no strabismus	□
□	**R ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**L ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**Nose:**	□ Patent, No congestion/discharge	□ Congested
□	**Oropharynx:**	□ Pink, moist, no lesions □ Teeth: Nl, no signs of caries	□
□	**Lungs:**	□ CTAB, no retractions, nl WOB	□
□	**CV:**	□ RRR, no murmur, strong femoral pulses, cap refill < 2 sec	□
□	**Abd:**	□ Soft, NT, no HSM, no mass, nl BS, no umbilical/inguinal hernia	□
□	**Ext/Spine:**	□ NL, FROM, nontender, no edema, no lumbosacral pits	□
□	**Skin:**	□ No rash, No bruises	□
□	**Hips:**	□ Full ROM, Symmetric leg folds	□
□	**Neuro:**	□ Normal tone/strength/symmetry	□
□	**Genitalia:**	□ Nl female/no adhesions □ Nl male, Testes down	
□	**Other findings:**	□	□

ASSESSMENT: Asthma: Mild Intermittent, Mild Persistent, Moderate Persisten, Sever Persistent
□ Controlled □ Uncontrolled

PLAN: Asthma action plan reviewed & copy given to parent. **PFTs ordered?** □ Yes □ No

F/U: _____ or sooner if increased inhaler use, worsening symptoms, or parental concern. Patient/parent verbalized understanding of the treatment and plan. □ Anticipatory guidance handout provided

PREVENTION: □Hand washing □Annual Flu Shot □Smoking Cessation □Avoidance of Triggers □Exercise □Nutrition □Media Time

Signature:_____ **Date:**_____
Stamp:

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

STANDARD FORM 600 Overprint

Childhood Asthma Control Test for children 4 to 11 years old.

Know the score.

This test will provide a score that may help your doctor determine if your child's asthma treatment plan is working or if it might be time for a change.

How to take the Childhood Asthma Control Test

Step 1 Let your child respond to **the first four questions (1 to 4).** If your child needs help reading or understanding the question, you may help, but let your child select the response. Complete the remaining **three questions (5 to 7)** on your own and without letting your child's response influence your answers. There are no right or wrong answers.

Step 2 Write the number of each answer in the score box provided.

Step 3 Add up each score box for the total.

Step 4 Take the test to the doctor to talk about your child's total score.

19 or less If your child's score is 19 or less, it may be a sign that your child's asthma is not controlled as well as it could be. No matter what the score, bring this test to your doctor to talk about your child's results.

Have your child complete these questions.

SCORE

1. How is your asthma today?

0	1	2	3
 Very bad	 Bad	 Good	 Very good

2. How much of a problem is your asthma when you run, exercise or play sports?

0	1	2	3
 It's a big problem, I can't do what I want to do.	 It's a problem and I don't like it.	 It's a little problem but it's okay.	 It's not a problem.

3. Do you cough because of your asthma?

0	1	2	3
 Yes, all of the time.	 Yes, most of the time.	 Yes, some of the time.	 No, none of the time.

4. Do you wake up during the night because of your asthma?

0	1	2	3
 Yes, all of the time.	 Yes, most of the time.	 Yes, some of the time.	 No, none of the time.

Please complete the following questions on your own.

5. During the last 4 weeks, on average, how many days per month did your child have any daytime asthma symptoms?

5	4	3	2	1	0
Not at all	1-3 days/mo	4-10 days/mo	11-18 days/mo	19-24 days/mo	Everyday

6. During the last 4 weeks, on average, how many days per month did your child wheeze during the day because of asthma?

5	4	3	2	1	0
Not at all	1-3 days/mo	4-10 days/mo	11-18 days/mo	19-24 days/mo	Everyday

7. During the last 4 weeks, on average, how many days per month did your child wake up during the night because of asthma?

5	4	3	2	1	0
Not at all	1-3 days/mo	4-10 days/mo	11-18 days/mo	19-24 days/mo	Everyday

TOTAL

Please turn this page over to see what your child's total score means.

Asthma Control Test™ for teens 12 years and older. Know the score.

If your teen is 12 years or older have him take the test now and discuss the results with your doctor

Step 1 Write the number of each answer in the score box provided.

Step 2 Add up each score box for the total.

Step 3 Take the test to the doctor to talk about your child's total score.

1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?

All of the time 1	Most of the time 2	Some of the time 3	A little of the time 4	None of the time 5

2. During the past **4 weeks**, how often have you had shortness of breath?

More than once a day 1	Once a day 2	3 to 6 times a week 3	Once or twice a week 4	Not at all 5

3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week 1	2 or 3 nights a week 2	Once a week 3	Once or twice 4	Not at all 5

4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times per day 1	1 or 2 times per day 2	2 or 3 times per week 3	Once a week or less 4	Not at all 5

5. How would you rate your **asthma** control during the past **4 weeks**?

Not controlled at all 1	Poorly controlled 2	Somewhat controlled 3	Well controlled 4	Completely controlled 5

AMERICAN LUNG ASSOCIATION.

The American Lung Association supports the Asthma Control Test and wants everyone 12 years of age and older with asthma to take it.

Total

What does it mean if my child scores 19 or less?

- If your child's score is 19 or less, it may be a sign that your child's asthma is not under control.
- Make an appointment to discuss your child's asthma score with their doctor. Ask if you should change your child's asthma treatment plan.
- Ask your child's doctor about daily long-term medications that can help control airway inflammation and constriction, the two main causes of asthma symptoms. Many children may need to treat both of these on a daily basis for the best asthma control.