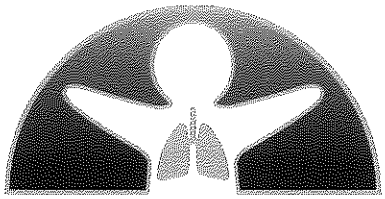
MaineHealth

Asthma Clinical Guidelines ≥12 Years

Adapted from the Global Initiative for Asthma (GINA) 2018 Guidelines for the Diagnosis and Management of Asthma and the National Heart, Lung, and Blood Institutes's (NHLBI) National Asthma Education and Prevention Program (NAEPP) 2007 Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma



INITIAL ASSESSMENT

Symptoms	Medical History	Comorbidities
• Recurrent wheezing • Coughing • Chest tightness • Expiratory airflow limitations • Dyspnea	• Pneumonia • Atopic dermatitis (eczema) • Allergies • Premature Birth • Recurrent bronchitis • Allergic rhinitis • Family history of asthma or allergy	• Rhinitis • Sinusitis • GERD • Obesity • OSA • Depression and anxiety

Risk factors that may exacerbate symptoms		Red flags
• Exercise • Recurrent Respiratory Tract Infections • Allergen exposure/sensitization • Changes in weather • Environmental Tobacco Smoke • Tobacco or marijuana use • Irritants (woodsmoke, airborne chemicals, strong smells)	• Stress • Menstrual cycles • Nocturnal symptoms • Strong emotional expressions	• History of steroid use • ED visits • Hospitalization

Differential diagnosis	Patients 40+ years
• Chronic upper airway cough syndrome • Bronchiectasis • Primary ciliary dyskinesia • Cystic fibrosis • Vocal cord dysfunction • Tuberculosis	• COPD • Bronchiectasis • Cardiac Failure • Interstitial/Diffuse Lung Disease

Features that decrease probability that respiratory symptoms are due to asthma	
• Chronic sputum production • Dyspnea associated with dizziness, light headeness or peripheral tingling	• Chest pain • Exercise-induced dyspnea with noisy inspiration

Diagnostics, Classification and Symtom Control Assessment ≥12 years

DIAGNOSTICS

Spirometry	Recommended Additional Testing
• Performed at diagnosis or start of treatment, after 3-6 months of controller treatment to assess the patient's personal best FEV_1, every 1-2 years, more frequently in at risk patients. • Lung function does not correlate strongly with asthma symptoms in adults and children; **a low FEV_1 is a strong independent predictor of risk of exacerbations, even after adjustment for symptom frequency.**	• Pulse Oximetry • CXR • Consider allergy testing

SEVERITY CLASSIFICATION

Components of Severity*		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment	Daytime symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2x/month	3-4x/month	>1x/week	7x/week
	SABA[1] use for symptom control[2]	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	Normal FEV_1 between exacerbations FEV_1>80% predicted FEV_1/FVC Normal	FEV_1>80% FEV_1/FVC Normal	FEV_1=60-80% FEV_1/FVC=70-75%	FEV_1<60% FEV_1/FVC<70%
Risk	Exacerbations requiring oral corticosteroids	0-1/yr	≥2 exacerbations in 1 year requiring oral corticosteroids †		

* Level of severity is determined by both impairment and risk. Assess impairment domain by patient's/caregiver's recall of the previous 2-4 weeks and spirometry (if ≥5yrs of age). Severity may be assigned to the most severe category in which any feature occurs.

† At present, there are inadequate data to correspond frequency of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients ≥5yrs of age who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

1 Short-acting inhaled $beta_2$-agonist.

2 Does not include SABA for prevention of exercise-induced bronchospasm.

Symptom Control Assessment			Level of Asthma Symptom Control		
In the past 4 weeks, has the patient had:	**Yes**	**No**	Well controlled	Partly controlled	Uncontrolled
Daytime asthma symptoms for more than a few minutes, more than twice a week?			None of these	1-2 of these	3 or more
Any activity limitation due to asthma? (Runs/plays less than other children, tires easily during walks/playing?) Missed work or school due to asthma?					
Reliever medication needed* more than twice a week?					
Any night waking or night coughing due to asthma?					
Have you been to a quick care or ED for your asthma since your last visit?					
Have you been prescribed an oral corticosteroid (OCS) for your asthma since your last visit?					

* Excludes reliever taken before exercise

STEPWISE APPROACH TO MANAGEMENT ≥12 YEARS

	Step 1	Step 2	Step 3	Step 4	Step 5
Preferred Controller		Low dose ICS	**Consider Consult with an Asthma Specialist** Medium dose ICS/LABA	**Refer to an Asthma Specialist** Medium/high ICS/LABA	**Refer to an Asthma Specialist** Refer for add-on treatment: LAMA* anti-IgE anti-IL5
Other Controller Options		LTRA	Med/high dose ICS Low dose ICS + LTRA	Add LAMA* High dose ICS + LTRA	Add low dose OCS
Reliever	As needed short-acting $beta_2$-agonist (SABA)				
Severity Classification**	**Intermittent**	**Mild Persistent**	**Moderate Persistent**	**Moderate to Severe Persistent**	**Severe Persistent**

KEY:	
SABA – short-acting $beta_2$ agonist	ICS – inhaled corticosteriod
LABA – long-acting $beta_2$ agonist	OCS – oral corticosteriod
LAMA – long-acting muscarinic antagonist	SMI – soft mist inhaler
LTRA – leukotriene receptor antagonist	

*Spiriva (tiotropium bromide respimat SMI) by mist inhaler is an add-on treatment for patients with a history of exacerbations.

**Asthma severity is assessed retrospectively from the level of treatment required to control symptoms and exacerbations. It can be assessed once the patient has been on controller treatment for several months and, if appropriate, treatment stepdown has been attempted to find the patient's minimum effective level of treatment. Asthma severity is not a static feature and may change over months or years.

MANAGEMENT

Assess symptom control over last 4 weeks- System Control Assessment

Tobacco treatment referral for:

- Patient if active tobacco user
- Parents/Caregivers if patient is exposed to environmental tobacco smoke

Influenza vaccine

Allergen avoidance

Pneumonia vaccine (up to date)

Set goals for managing asthma and medications

Assess and treat comorbidities

Self-management education

- Written asthma action plan
- Inhaler education with teach back*
- Assess adherence

Physical activity

Annual visits

* "Inhaler competence in asthma: Common errors, barriers to use and recommended solutions." Respiratory Medicine. October 23, 2012 https://www.sciencedirect.com/science/article/pii/S0954611112003587

DAILY DOSES OF INHALED CORTICOSTEROIDS

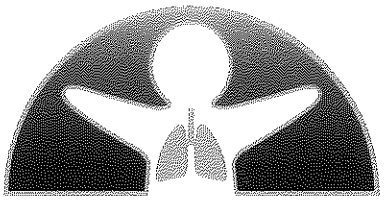
Brand name	Corticosteroid	Low	Medium	High
Asmanex Twisthaler	Mometasone furoate (DPI)	110 mcg or 220 mcg 1 puff once daily	220 mcg or 440 mcg 1 puff once daily	440 mcg 2 puffs once daily
Asmanex	Mometasone furoate (HFA)	90 mcg 2 puffs once daily	200 mcg 2 puffs once daily	200 mcg 2 puffs twice daily
Arnuity Ellipta	Fluticasone furoate (DPI)	100 mcg 1 puff once daily	200 mcg 1 puff once daily	200 mcg 1 puff twice daily
Flovent Diskus	Fluticasone propionate (DPI)	50 mcg 1 puff twice daily	100 mcg 1 puff twice daily	250 mcg or 500 mcg 1 puff twice daily
Flovent	Fluticasone propionate (HFA)	44 mcg 2 puffs twice daily	110 mcg 2 puffs twice daily	220 mcg 2 puffs twice daily
Pulmicort Flexhaler	Budesonide (DPI)	90 mcg 1 puff twice daily	180 mcg 1 puff twice daily	180 mcg 2 puffs twice daily
QVAR	Beclomethasone dipropionate (HFA) or RediHaler (DPI)	40 mcg 2 puffs twice daily	80 mcg 2 puffs twice daily	80 mcg 4 puffs twice daily

For more information, contact MaineHealth Pediatric Service Line Program Manager at 207-662-2439

MaineHealth

Asthma Clinical Guidelines 0-5 Years

Adapted from the Global Initiative for Asthma (GINA) 2018 Guidelines for the Diagnosis and Management of Asthma and the National Heart, Lung, and Blood Institutes's (NHLBI) National Asthma Education and Prevention Program (NAEPP) 2007 Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma



INITIAL ASSESSMENT

Symptoms

- Recurrent wheezing
- Coughing
- Recurrent Respiratory Tract Infections

Comorbidities

- Rhinitis

Medical History

- Allergic rhinitis
- Premature Birth
- Family history (1st degree relative) of asthma or allergy
- Atopy present in the majority of children with asthma who are over 3 years old
- Allergen specific sensitization is one of the most important risk factors for the development of asthma

Risk factors that may exacerbate symptoms

- Allergen exposure/sensitization
- Environmental Tobacco/Marijuana Smoke
- Irritants (woodsmoke, airborne chemicals, strong smells)
- Reactive airway disease
- Nocturnal symptoms

Red flags

- History of steroid use
- ED visits
- Hospitalization

Differential diagnosis

- Upper respiratory tract infections (e.g. RSV and Rhinovirus) are associated with recurrent wheezing throughout childhood*
- Recurrent viral respiratory tract infections
- GERD
- Foreign body aspiration
- Tracheomalacia
- Tuberculosis
- Bronchopulmonary dysplasia
- Cystic fibrosis
- Primary ciliary dyskinesia
- Vascular ring
- Congenital heart disease
- Immune deficiency

* Global Strategy for Asthma Management and Prevention (GINA) page 100

DIAGNOSTICS

Features suggesting a diagnosis of asthma in children 5 years and younger	
Feature	**Characteristics suggesting asthma**
Cough	Recurrent or persistent non-productive cough that may be worse at night accompanied by some wheezing and breathing difficulties. Cough occurring with exercise, laughing, crying or exposure to tobacco smoke in the absence of an apparent respiratory infection
Wheezing	Recurrent wheezing, including during sleep or with triggers such as activity, laughing, crying or exposure to tobacco smoke or air pollution
Difficult or heavy breathing or shortness of breath	Occurring with exercise, laughing, or crying
Reduced activity	Not running, playing or laughing at the same intensity as other children; tires earlier during walks (wants to be carried)
Past or family history	Other allergic disease (atopic dermatitis or allergic rhinitis) Asthma in first-degree relatives
Threrapeutic trial with low dose inhaled corticosteroid and as-needed short-acting beta$_2$-agonist, SABA*	Clinical improvement during 2-3 months of controller treatment and worsening when treatment stopped

* Due to the variable nature of asthma in young children, a therapeutic trial may need to be repeated in order to be certain of the diagnosis. GINA page 103

Key indications for referral of a child 5 years or younger for further diagnostic investigations

Any of the following features suggest an alternative diagnosis and indicate the need for further investigations:

- Failure to thrive
- Neonatal or very early onset symptoms (especially if associated with failure to thrive)
- Vomiting associated with respiratory symptoms
- Continuous wheezing
- Failure to respond to asthma controller medications
- No asscociation of symptoms with typical triggers, such as viral respiratory tract infections
- Focal lung or cardiovascular signs, or finger clubbing
- Hypoxemia outside context of viral illness

Testing:

- Pulse Oximetry
- CXR to R/O structural abnormalities (congenital lobar emphysema, vascular rings), chronic infections such as TB, an inhaled foreign body

Classification and Symptom Control Assessment 0-5 years

SEVERITY CLASSIFICATION

Components of Severity*		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment	Daytime symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	None	1-2x/month	3-4x/month	>1x/week
	SABA[1] use for symptom control[2]	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	n/a	n/a	n/a	n/a
Risk	Exacerbations requiring oral corticosteroids	0-1/yr	≥2 exacerbations in 6 months requiring oral corticosteroids or ≥4 wheezing episodes/year lasting >1 day AND risk factors for persistent asthma†		

* Level of severity is determined by both impairment and risk. Assess impairment domain by patient's/caregiver's recall of the previous 2-4 weeks and spirometry (if ≥5yrs of age). Severity may be assigned to the most severe category in which any feature occurs.

† At present, there are inadequate data to correspond frequency of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients ≥5yrs of age who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

1 Short-acting inhaled $beta_2$-agonist.

2 Does not include SABA for prevention of exercise-induced bronchospasm.

Symptom Control Assessment			Level of Asthma Symptom Control		
In the past 4 weeks, has the child had:	**Yes**	**No**	Well controlled	Partly controlled	Uncontrolled
Daytime asthma symptoms for more than a few minutes, more than twice a week?			None of these	1-2 of these	3 or more
Any activity limitation due to asthma? (Runs/plays less than other children, tires easily during walks/playing?)					
Reliever medication needed* more than twice a week?					
Any night waking or night coughing due to asthma?					
Have you been to a quick care or ED since your last visit?					
Have you been prescribed OCS, oral corticosteroid, since your last visit?					

* Excludes reliever taken before exercise

Stepwise Approach, Management and Inhaled Corticosteroids 0-5 years

STEPWISE APPROACH TO MANAGEMENT 0-5 YEARS

	Step 1	Step 2	Step 3	Step 4
Preferred Controller		Daily low dose ICS	**Refer to an Asthma Specialist** Double low dose ICS	**Refer to an Asthma Specialist** Continue controller and refer for specialist assessment
Other Controller Options		LTRA	Low dose ICS + LTRA	Add LTRA include ICS frequency
Reliever	As-needed SABA (all children)			
Severity Classification*	**Intermittent**	**Mild Persistent**	**Moderate Persistent**	**Severe Persistent**

KEY:

SABA – short-acting $beta_2$ agonist

LABA – long-acting $beta_2$ agonist

LTRA – leukotriene receptor antagonist

ICS – inhaled corticosteroid

*Asthma severity is assessed retrospectively from the level of treatment required to control symptoms and exacerbations. It can be assessed once the patient has been on controller treatment for several months and, if appropriate, treatment stepdown has been attempted to find the patient's minimum effective level of treatment. Asthma severity is not a static feature and may change over months or years.

MANAGEMENT

Assess symptom control over last 4 weeks- System Control Assessment

Tobacco treatment referral for parents/caregivers if patient exposed to environmental tobacco smoke

Influenza vaccine

Allergen avoidance

Pneumococcal vaccine

Set goals for managing asthma and medications

Assess and treat comorbidities

Self-management education

- Written asthma action plan
- Inhaler education with teach back*
- Assess adherence

Annual visits

* "Inhaler competence in asthma: Common errors, barriers to use and recommended solutions." Respiratory Medicine. October 23, 2012 https://www.sciencedirect.com/science/article/pii/S0954611112003587

LOW DAILY DOSES OF INHALED CORTICOSTEROIDS

Brand name	Corticosteroid	Low daily dose
Flovent	Fluticasone propionate (HFA)	44 mcg 2 puffs twice daily
Pulmicort	Budesonide (nebulized)	0.5 mg once daily
QVAR	Beclomethasone dipropionate (HFA)	40 mcg 2 puffs twice daily

Choosing an inhaler device for children 5 years and younger

Age	Preferred device	Alternate device
0-3 years	Pressurized metered-dose inhaler plus dedicated spacer with face mask	Nebulizer with face mask
4-5 years*	Pressurized metered-dose inhaler plus dedicated spacer with mouthpiece	Pressurized metered-dose inhaler plus dedicated spacer with face mask or nebulizer with mouthpieceor face mask

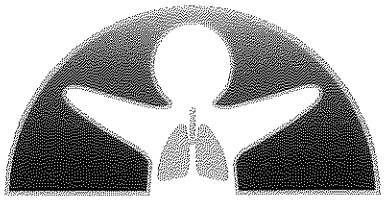
* Please consider development stage when prescribing for pediatric patients.

For more information, contact MaineHealth Pediatric Service Line Program Manager at 207-662-2439

MaineHealth

Asthma Clinical Guidelines 6-11 Years

Adapted from the Global Initiative for Asthma (GINA) 2018 Guidelines for the Diagnosis and Management of Asthma and the National Heart, Lung, and Blood Institutes's (NHLBI) National Asthma Education and Prevention Program (NAEPP) 2007 Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma



INITIAL ASSESSMENT

Symptoms	Medical History	Comorbidities
• Recurrent wheezing • Coughing • Chest tightness • Expiratory airflow limitations • Dyspnea	• Pneumonia • Atopic dermatitis (eczema) • Allergies • Premature Birth • Recurrent bronchitis • Allergic rhinitis • Family history of asthma or allergy	• Rhinitis • Sinusitis • GERD • Obesity • OSA • Depression and anxiety

Risk factors that may exacerbate symptoms		Red flags
• Exercise • Recurrent Respiratory Tract Infections • Allergen exposure/sensitization • Changes in weather • Environmental Tobacco/Marijuana Smoke • Irritants (woodsmoke, airborne chemicals, strong smells)	• Stress • Menstrual cycles • Nocturnal symptoms • Strong emotional expressions	• History of steroid use • ED visits • Hospitalization

Differential diagnosis	Features that decrease probability that respiratory symptoms are due to asthma
• Chronic upper airway cough syndrome • Inhaled foreign body • Bronchiectasis • Primary ciliary dyskinesia • Congenital heart disease • Cystic fibrosis • Vocal cord dysfunction • Tuberculosis	• Chronic sputum production • Dyspnea associated with dizziness, light headedness or peripheral tingling • Chest pain • Exercise-induced dyspnea with noisy inspiration

Diagnostics, Classification and Symptom Control Assessment 6-11 years

DIAGNOSTICS

Spirometry	Recommended Additional Testing
• Performed at diagnosis or start of treatment, after 3-6 months of controller treatment to assess the patient's personal best FEV_1, every 1-2 years, more frequently in at risk patients. • Lung function does not correlate strongly with asthma symptoms in adults and children; **a low FEV_1 is a strong independent predictor of risk of exacerbations, even after adjustment for symptom frequency.**	• Pulse Oximetry • CXR • Consider allergy testing

SEVERITY CLASSIFICATION

Components of Severity*		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment	Daytime symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	<2x/month	3-4x/month	>1x/week	7x/week
	SABA[1] use for symptom control[2]	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	Normal FEV_1 between exacerbations FEV_1>80% predicted FEV_1/FVC>85%	FEV_1>80% FEV_1/FVC>80%	FEV_1=60-80% FEV_1/FVC=75-80%	FEV_1<60% FEV_1/FVC<75%
Risk	Exacerbations requiring oral corticosteroids	0-1/yr	≥2 exacerbations in 1 year requiring oral corticosteroids †		

* Level of severity is determined by both impairment and risk. Assess impairment domain by patient's/caregiver's recall of the previous 2-4 weeks and spirometry (if ≥5yrs of age). Severity may be assigned to the most severe category in which any feature occurs.

† At present, there are inadequate data to correspond frequency of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients ≥5yrs of age who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

1 Short-acting inhaled $beta_2$-agonist.

2 Does not include SABA for prevention of exercise-induced bronchospasm.

Symptom Control Assessment			Level of Asthma Symptom Control		
In the past 4 weeks, has the child had:	**Yes**	**No**	**Well controlled**	**Partly controlled**	**Uncontrolled**
Daytime asthma symptoms for more than a few minutes, more than twice a week?			None of these	1-2 of these	3 or more
Any activity limitation due to asthma? (Runs/plays less than other children, tires easily during walks/playing?)					
Reliever medication needed* more than twice a week?					
Any night waking or night coughing due to asthma?					
Have you been to a quick care or ED for your asthma since your last visit?					
Have you been prescribed an oral corticosteroid (OCS) for your asthma since your last visit?					

* Excludes reliever taken before exercise

STEPWISE APPROACH TO MANAGEMENT 6-11 YEARS

	Step 1	Step 2	Step 3	Step 4	Step 5
Preferred Controller		Low dose ICS	**Consider Consult with an Asthma Specialist** Medium dose ICS	**Refer to an Asthma Specialist** Medium/high ICS + LABA	**Refer to an Asthma Specialist** Add-on treatment: anti-IgE High ICS + LABA
Other Controller Options		LTRA	LTRA	Low dose ICS +	High dose ICS
Reliever	As needed short-acting $beta_2$-agonist (SABA)			SABA prn or low dose ICS/formoterol	
Severity Classification*	**Intermittent**	**Mild Persistent**	**Moderate Persistent**	**Moderate to Severe Persistent**	**Severe Persistent**

KEY:	
SABA – short-acting $beta_2$ agonist	LTRA – leukotriene receptor antagonist
LABA – long-acting $beta_2$ agonist	ICS – inhaled corticosteriod

*Asthma severity is assessed retrospectively from the level of treatment required to control symptoms and exacerbations. It can be assessed once the patient has been on controller treatment for several months and, if appropriate, treatment stepdown has been attempted to find the patient's minimum effective level of treatment. Asthma severity is not a static feature and may change over months or years.

MANAGEMENT

Assess symptom control over last 4 weeks- System Control Assessment

Tobacco treatment referral for parents/caregivers if patient exposed to environmental tobacco smoke

Influenza vaccine

Allergen avoidance

Pneumococcal vaccine

Set goals for managing asthma and medications

Assess and treat comorbidities

Self-management education

- Written asthma action plan
- Inhaler education with teach back*
- Assess adherence

Annual visits

* "Inhaler competence in asthma: Common errors, barriers to use and recommended solutions." Respiratory Medicine. October 23, 2012 https://www.sciencedirect.com/science/article/pii/S0954611112003587

DAILY DOSES OF INHALED CORTICOSTEROIDS

Brand name	Corticosteroid	Low	Medium	High
Asmanex Twisthaler*	Mometasone furoate (DPI)	110 mcg 1 puff once daily	220 mcg 1 puff once daily	220 mcg 2 puffs once daily
Arnuity Ellipta	Fluticasone furoate (DPI)	100 mcg 1 puff once daily	200 mcg 1 puff once daily	200 mcg 1 puff twice daily
Flovent	Fluticasone propionate (DPI)	50 mcg 1 puff twice daily	100 mcg 1 puff twice daily	250 mcg 1 puff twice daily
Flovent	Fluticasone propionate (HFA)	44 mcg 2 puffs twice daily	110 mcg 2 puffs twice daily	220 mcg 2 puffs twice daily
Pulmicort	Budesonide (DPI)	90 mcg 1 puff twice daily	180 mcg 1 puff twice daily	180 mcg 2 puffs twice daily
Pulmicort	Budesonide (respules)	0.25 mg twice daily or 0.5 mg once daily	0.5 mg twice daily	1 mg twice daily
QVAR	Beclomethasone dipropionate (HFA)	40 mcg 2 puffs twice daily	80 mcg 2 puffs twice daily	80 mcg 4 puffs twice daily

* Please consider development stage when prescribing for pediatric patients
Consider use of aerochamber with medium mask through age 10.

For more information, contact MaineHealth Pediatric Service Line Program Manager at 207-662-2439

MaineHealth

ASTHMA SYMPTOM ASSESSMENT

These 6 questions help us know how well the asthma treatment plan is working for you/your child.

Please answer the questions below:	Yes	No
During the last 4 weeks, have you/your child had any asthma symptoms during the day that last for more than a few minutes. Has that happened more than twice a week?		
During the last 4 weeks, have you/your child's asthma caused any problems with activities like running or playing? Have you/your child missed work or school due to asthma?		
During the last 4 weeks, have you/your child had to use quick relief medicines more than twice a week to help control asthma symptoms? This would not include medicines used before exercise.		
During the last 4 weeks, have you/your child's asthma woken them up at night? Have you/your child had night coughing due to asthma?		
Since your last visit, have you been to/taken your child to a quick care or emergency room because of asthma symptoms?		
Since your last visit, have you/your child taken liquid or pill steroid medicine like prednisone for asthma?		
Total		

Level of Asthma Symptom Control		
	Well Controlled	0 YES answers
	Partly Controlled	1-2 YES answers
	Uncontrolled	3 or more YES answers