

ATAQ

Asthma Therapy Assessment Questionnaire*

Take a step toward control



PEDIATRIC/ADOLESCENT
(5-17 YEARS OLD)

Patient's name: _____

ID number: _____

Physician's name: _____ Date: _____

Physician: Please have the parent or guardian complete this questionnaire.

Instructions: Check 1 answer for each question and enter point value (0 or 1) on line. _____

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) 1 to 2 (0) 3 to 4 (1)[†] 5 to 6 (1) More than 6 (1)

Enter score _____

3. Do you believe that your child's asthma was well controlled in the past 4 weeks?

- Yes (0) No (1) Unsure (1)

Add the numbers in the blue area and enter the total score here.

TOTAL _____

If the score is 1 or greater, discuss the questionnaire with your child's doctor.

*The control domain is 1 domain of the ATAQ instrument. Other disease management domains are included in the complete instrument.

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

20850556(4)-04/08-SNG

Parent or guardian: Detach here and keep this part.

Continue to monitor your child's asthma control at asthmacontrolcheck.com

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