

DESCRIPTION OF ASTHMA CONTROL FEATURES

Night-time symptoms

Children with asthma may experience night-time symptoms, such as coughing, rapid breathing, shortness of breath or other symptoms that cause sleep disruption. Your child's night-time symptoms may be:

- None
- 3 days per week
- 5 days per week

Wheezing or tightening of chest

How often a child experiences wheezing or tightening of the chest at any time varies from child to child. Your child may experience:

- No chest tightening or wheezing
- Chest tightening or wheezing but it is manageable (does not worsen)
- Chest tightening or wheezing and is bothersome (may worsen)

Changing medication

When asthma symptoms worsen your child may have to make a change to his or her regular asthma medication. Depending on the severity of asthma symptoms, your child may need:

- No changes to medication
- More doses or to add on another asthma medication

- To add oral steroids for 5 days

Emergency visits

The number of asthma attacks your child experiences can vary depending on the severity of asthma and on how well asthma is being managed. Sometimes the exacerbation may be out of your control and you would need to take your child to the Emergency room at the hospital. Your child may experience:

- No Emergency room visits
- 1 Emergency room visit per year
- 4 Emergency room visits per year
- 10 Emergency room visits per year

Participation in physical activities

Your child's asthma may get worse during physical activities such as running, playing sports or during dance class. Your child might have to stop in the middle of a physical activity to get his or her breathing back to normal. How often a child is unable to continue with a physical activity after a flare up varies from child to child. Your child may experience:

- No physical activity limitations
- 2 limitations per month
- 10 limitations per month

BALANCED INCOMPLETE BLOCK DESIGN INSTRUMENT

Considering the following choices of attributes and their levels, please indicate which one you consider as the **most preferred (best)** and which one you consider as the **least preferred (worst)** attribute in asthma control.

Please choose only one best and only one worst.

Best		Worst
<input type="checkbox"/>	<u>Night-time symptoms:</u> <u>3 days per week</u>	<input type="checkbox"/>
<input type="checkbox"/>	<u>Wheezing or tightening of chest:</u> <u>No chest tightening or wheezing</u>	<input type="checkbox"/>
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<input type="checkbox"/>	<u>Emergency visits:</u> <u>1 Emergency room visits per year</u>	<input type="checkbox"/>
<input type="checkbox"/>	<u>Limitation of physical activities:</u> <u>10 limitations per month</u>	<input type="checkbox"/>

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ORTHAGONAL MAIN EFFECTS PLAN INSTRUMENT

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