



Name _____ DOB _____ Today's date _____

Pharmacy _____

Since our last visit have you experienced any of the following:

(circle yes or no)

Nighttime cough or wheeze	Yes	No
Cough with exercise	Yes	No
Visited ER/Urgent care	Yes	No
Severe difficulty breathing	Yes	No
Missed school/work days due to asthma	Yes	No

Circle yes or no for the following questions: Do you ...

Take a preventative inhaler? Yes No

Use preventative inhaler EVERYDAY? Yes No

Have a rescue inhaler, spacer, and signed medication administration forms at school? Yes No

ALWAYS use inhaler with a spacer? Yes No

Use the same pharmacy to fill prescription medications? Yes No

Needed a rescue inhaler when otherwise healthy? Yes No

(please do not include use before exercise)

Not including before exercise use, how many times a week (on average) do you use your rescue inhaler? _____

Rate the last asthma attack's severity on a scale from 1 to 10

No attacks 1 2 3 4 5 6 7 8 9 10 most severe

Check if you have experienced any of the following :

- | | |
|--|--|
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Purulent nasal drainage |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nighttime cough |
| <input type="checkbox"/> Throat clearing | <input type="checkbox"/> Recent fevers |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Shortness of breath |

Social History

List any sports you participate in _____

Please list ALL medications you take below:

Preventative inhaler name: _____

Rescue inhaler: _____

Others: _____

Patient completes above this line

Physician or Provider to complete below

Physical Exam

Ht _____ Wt _____ BP _____ O2 sat _____%

√ = normal X = abnormal

- General:
- HEENT:
- Lungs:
- Heart:
- Abdomen:
- Femoral Pulses:
- Skin:
- Other:

Impression

Asthma

- Intermittent (short-acting β -agonist (SABA) only)
- Mild persistent (low dose ICS OR Singulair PLUS SABA)
- Mod persistent (Low dose ICS+Singulair or Medium dose ICS)
- Severe Persistent (Combination ICS/LABA therapy)
- Other _____

Plan:

- Written action plan discussed/given to patient/parent
- Pharmacy records reviewed/medications prescribed
- Medications: _____
- Immunizations _____
- Individual vaccine component counseling provided by MD, PA or NP
- Counseling provided included the topics below

Prevention:

Mattress/Pillow encasements
 Smoke Free Environment
 Avoid opening windows
 Central Heat and Air

Triggers:

Cold or weather changes
 Exercise or play
 Pollutants, cig smoke, perfumes
 Emotional (laughing, crying, fear)

RTC in _____ Signed _____

ASTHMA FOLLOW-UP (ADOLESCENT)

Nurse Initials _____