



Name of Patient \_\_\_\_\_ DOB \_\_\_\_\_ Today's date \_\_\_\_\_

Name of person completing form \_\_\_\_\_ Relationship to Pt \_\_\_\_\_ Pharmacy \_\_\_\_\_

**Since our last visit has your child 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 due to asthma | Yes | No |

**Circle yes or no for the following questions:**

**Does your child ...**

- |                                    |     |    |
|------------------------------------|-----|----|
| 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 use before exercise, how many times a week (on average) does your child use a rescue inhaler? \_\_\_\_\_

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

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

**Check if your child has 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 or your child participates in \_\_\_\_\_

**List your child's medications below:**

Preventative inhaler name: \_\_\_\_\_

Rescue inhaler: \_\_\_\_\_

Others: \_\_\_\_\_

Parents/Patients complete 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))
- 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 (CHILD)**

Nurse Initials \_\_\_\_\_