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Blue Ridge Pediatrics

Professional, Personalized Care for Newborns, Children & Adolescents

North Park Office Park
457-B Hwy 123 Bypass
Seneca, SC 29678

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? (please do not include use before exercise)	Yes No

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 :

- ☐ Itchy eyes
- ☐ Heartburn
- ☐ Throat clearing
- ☐ Facial pain
- ☐ Purulent nasal drainage
- ☐ Nighttime cough
- ☐ Recent fevers
- ☐ 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 ß-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_____