Asthma Physician-Patient Encounter Form– Adult

Name: ________________ Age___ Phone________ Date_________
Med. Allergies: ____________________________________

HISTORY OF PRESENT ILLNESS

Type of Visit: ☐ Maintenance ☐ Acute

____
____
____

CURRENT MEDICATIONS

____
____

Use of quick relief inhaler in the last week: ☐ No ☐ Yes If yes, how many times?__________

VITALS

Ht. ______ ↑ Wt. ______ ↑ ↓ BMI _____ T. _______ P. ______ RR ______ BP _______

PHYSICAL EXAM

Lungs:
☐ Clear
☐ Wheezing
☐ Poor air movement

I:E Ratio __________
☐ Normal
☐ Prolonged

Retractions
☐ None ☐ Moderate
☐ Mild ☐ Severe

	WNL	N/A
ENT:		
Sinus tenderness	☐	☐
Cardiac	☐	☐
______________		
Abdomen	☐	☐
______________		
Musculoskeletal	☐	☐
Neuro	☐	☐
Skin	☐	☐

Pulse oxymetry: ☐ No ☐ Yes ____
If yes, SaO_2: _____
Spirometry: ☐ No ☐ Yes
If yes, list readings

FVC	☐ NL	☐ ABN	____
FEV_1	☐ NL	☐ ABN	____
$\%FEV_1$	☐ NL	☐ ABN	____
FEF 25-75	☐ NL	☐ ABN	____

☐ see printout, if applicable

ASSESSMENT

Stage	Daytime symptoms	Nighttime symptoms	FEV_1, % predicted
☐ **Mild intermittent**	≤ 2x / week	≤ 2x / month	≥ 80%
☐ **Mild persistent**	3-6x / week	3-4x / month	≥ 80%
☐ **Moderately persistent**	Daily	≥ 5x/ month	60-80%
☐ **Severe persistent**	Constant	Frequent	≤ 60%

Does current stage match current therapy? ☐ No ☐ Yes
If rating is lower than current therapy, step down.
If rating is higher than current therapy, step up.

PLAN

Medications:
Controller: ☐ QVAR 40 mcg ____________ ☐ QVAR 80 mcg ____________
☐ Aerobid 250 mcg ____________ ☐ Other: ____________
Quick-relief inhaler: ____________________
Other: ____________________
Additional interventions: ____________________
____

ADDITIONAL COMMENTS

PEAK FLOW

Personal best: ______
Expected: ______
Today: ______
Recent low: ______

RESPIRATORY HISTORY

ER visits in the last 6 months: ____
Hospitalizations/ ICU/ intubated in the last 3 months: ______
Family History: ☐ No ☐ Yes
Smoker? ☐ No ☐ Yes
If yes, how long? ______________
how much? ______________
Plan to quit? ☐ No ☐ Yes
If yes, when? ________________

TRIGGERS

☐ Cigarette smoke ☐ Cold/ Flu
☐ Environment ☐ Chemicals
☐ Pets ☐ Exercise
☐ Other ____________________

ASTHMA ACTION PLAN

☐ Action plan completed, reviewed, and sent with patient

Action plan/encounter form sent to:
☐ HPSM
☐ Other provider ______________

EDUCATION

Needed	Done
☐ Symptoms / warning signs	☐
☐ Smoking/ environment/ pets	☐
☐ Other triggers____________	☐
☐ Use of MDI and Spacer	☐
☐ Peak flow / monitoring	☐
☐ Other ________________	☐

TRAINING

☐ Patient uses spacer/ reviewed
☐ Patient uses peak flow meter/ reviewed
☐ Asthma diary sent with patient

FOLLOW UP

Next visit: ________________
Referral: ________________

Provider Name: ______________________ Signature: ______________________

Adapted from MaineHealth