Asthma Physician-Patient Encounter Form– Child

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

ENT:	WNL	N/A
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 severity match current therapy? ☐ No ☐ Yes
If severity rating is lower than current therapy, step down.
If severity 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

Premature: ☐ N ☐ Y
Chronic lung dz (BPD): ☐ N ☐ Y
Age asthma first dx'd _____
Family History: ☐ N ☐ Y
RSV: ☐ N ☐ Y (Date: _____)
ER visits in the last 6 months: ____
Hospitalizations/ ICU/ intubated in the last 3 months: _____

TRIGGERS

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

ASTHMA ACTION PLAN

☐ Action plan completed, reviewed, and sent with pt/ parent

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

EDUCATION

Needed	**Done**
☐ Symptoms / warning signs	☐
☐ Smoking/environment/pets	☐
☐ Other triggers_____	☐
☐ Use of MDI and Spacer	☐
☐ Peak flow / monitoring	☐
☐ Partnership w/ school/daycare	☐
☐ Safety / development	☐
☐ 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