

ASTHMA PROGRESS NOTE



Name:	IEHP ID:	Age:	Date:	
C/C:		Spacer Use:		
Interval History (This present illness):		Peak Flow:		
		O ₂ Sat:		
		<input type="checkbox"/> Cigarette Smoke Exposure		
Current Medications:		Allergies		
Hospital/ED Visits:		<input type="checkbox"/> Drug: _____		
Exercise Tolerance:		<input type="checkbox"/> Environmental <input type="checkbox"/> Pets		
Temp: _____ Pulse: _____ RR: _____ BP: _____ Wt: _____ lbs. Ht: _____ ' _____ "				
	Normal ()	If abnormal, describe below:	Plan:	
Skin:				
Ears:				
Eyes:				
Nose:				
Mouth:			Next Follow-Up Visit:	
Head/Neck/Nodes:				
Throat:				
Lungs:				
Diagnosis:			Referral:	
Day Symptoms	Night Symptoms	β Agonist Use	Assessment of Severity	Treatment (Circle)
≤ 2 days per week	≤ 2 nights per month	≤ twice per week	Mild Intermittent	None
				Short Acting β-agonist/Albuterol
> 2 days per week	> 2 nights per month	> twice per week	Mild Persistent	Inhaled Corticosteroid
Daily	> 1 night per week	Daily	Moderate Persistent	Cromolyn
Continual/Frequent/Daily and Nocturnal Symptoms			Severe Persistent	Leukotriene
				Long Acting Bronchodilator
Asthma Action Plan Given/Discussed: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Asthma Education:	<input type="checkbox"/> Asthma Treatment/Medications		<input type="checkbox"/> Referred to Asthma Class	
	<input type="checkbox"/> Peak Flow Meter/Inhaler		<input type="checkbox"/> Smoking in home <input type="checkbox"/> MDI Use	

Physician Name: _____ Signature: _____