INLAND EMPIRE HEALTH PLAN

MOLINA HEALTHCARE

ASTHMA PROGRESS NOTE

Name: _____ DOB: _____ Age: _____ Date: _____

C/C: _____

Medical History (This present illness): _____

_____

_____

Recent Hospitalization/ED Visits: _____

Self-Treatment of Asthma Exacerbation: ❑ None ❑ One Per Month ❑ One Per Week ❑ > Twice Per Week

Nocturnal Symptoms: Cough ❑ None ❑ < Twice Per Month ❑ > Twice Per Month ❑ > Once Per Week

Allergies: Drug: _____ ❑ Environmental ❑ Pets ❑ Cigarette Smoke

Exercise Tolerance: ❑ Poor ❑ Fair ❑ Good

Medication: Current:

Temp: _____ Pulse: _____ RR: _____ BP: _____

Weight: _____Lbs. Height: _____' _____"

Peak Flow: _____

_____

_____

_____

_____

Spirometry: _____

_____

_____

_____

_____

O_2 Sat: _____

_____

_____

	Normal ( )	If Abnormal, Describe Below:
Skin:		
Ears:		
Eyes:		
Nose:		
Mouth:		
Head/Neck/Nodes:		
Throat:		
Lungs:		
Diagnosis:		

Assessment of Severity: ❑ Mild Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent

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Plan:	Treatment: Long-Term Control
	❑ Anti-Inflam : Inhaled Corticosteroid
	❑ Cromolyn / Nedocromil
	❑ Leukotriene Antagonist
	❑ Long-Acting Bronchodilator
	Treatment: Quick Relief
	❑ Short-Acting Beta Agonist: Albuterol

Pt. Ed. Discussed ❑ Yes ❑ No

❑ Asthma Pamphlet ❑ Asthma Treatment ❑ Referred to Asthma Class ❑ Peak Flow Meter
❑ Medications ❑ Smoking in home ❑ Inhaler ❑ Pt. and family Ed. Re: Asthma

Signature: _____