ASTHMA PROGRESS NOTE

Name:	**Med. Rec.:**	**Age:**	**Date:**
C/C:			**Spacer Use:**
Interval History (this present illness)**:**			**Peak Flow:**
			O2 Sat:
			❑ **Cigarette Smoke Exposure**
Current Medications:			**Allergies**
Hospital/ED Visits:			❑ **Drug:**
Exercise Tolerance:			❑ **Environmental** ❑ **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**	**ß Agonist Use**	**Assessment of Severity**	**Treatment (Circle)**
≤ 2 days per week	≤ 2 nights per month	≤ 2x per week	Mild Intermittent	None Short Acting ß-agonist/Albuterol
> 2 days per week	> 2 nights per month	> 2x per week	Mild Persistent	**Inhaled Corticosteroid** may add: Cromolyn Leukotriene inhibitor Long-acting bronchodilator
Daily	> 1 night per week	Daily	Moderate Persistent	
Continual/Frequent/Daily and Nocturnal Symptoms			Severe Persistent	

Asthma Action Plan Given/Discussed: ❑ **Yes** ❑ **No**

Asthma Education:	❑ **Asthma Treatment/Medications**	❑ **Referred to Asthma Class**	
	❑ **Peak Flow Meter/Inhaler**	❑ **Smoking in home**	❑ **MDI Use**

Physician Name: _____ Signature: _____

Adapted with permission from Inland Empire Health Plan