

ASTHMA FOCUSED FOLLOW-UP VISIT

Patient Section

Patient Name: _____ **Date:** _____ **Age:** _____ **ACT Test Score** _____

Why are you here today?

Current asthma symptoms

- Cough Short of breath
 Wheeze Difficulty breathing
 Chest Tightness Difficulty exercising
 Difficulty breathing at night
 Other _____

Current other symptoms

- Rash Heartburn Painful urination Headache
 Congestion Diarrhea Other _____
 Sore throat Constipation Fatigue
 Ear pain Muscle pain Depression

Known allergies:

Allergy testing:

Who tested?: _____ Date: _____ Results: _____

Do you see a pulmonologist? Y N (Doctor name) _____ **Date last seen** _____

Do you see an allergist? Y N (Doctor name) _____ **Date last seen** _____

Asthma Medicine Treatment Plan (check medications):

Allergy Medicines:

<i>Rescue Medicine:</i>	<i>Controller Medicines:</i>	<input type="checkbox"/> Accolate <input type="checkbox"/> Singulair <input type="checkbox"/> Cromolyn <input type="checkbox"/> Tilade <input type="checkbox"/> Foradil <input type="checkbox"/> Prednisone <input type="checkbox"/> Symbicort <input type="checkbox"/> Other	<i>Other asthma medications:</i>	Pills	Nasal Sprays:	Eye Drops:
<input type="checkbox"/> Albuterol <input type="checkbox"/> Maxair <input type="checkbox"/> Proventil <input type="checkbox"/> Ventolin <input type="checkbox"/> Other _____	<input type="checkbox"/> Advair <input type="checkbox"/> Aerobid <input type="checkbox"/> Asmanex <input type="checkbox"/> Flovent <input type="checkbox"/> Pulmicort <input type="checkbox"/> Qvar	<input type="checkbox"/> Serevent <input type="checkbox"/> Spireva <input type="checkbox"/> Atrovent <input type="checkbox"/> Theophylline	<input type="checkbox"/> Allegra <input type="checkbox"/> Claritin <input type="checkbox"/> Zyrtec <input type="checkbox"/> Other _____	<input type="checkbox"/> Flonase <input type="checkbox"/> Nasonex <input type="checkbox"/> Rhinocort <input type="checkbox"/> Veramyst <input type="checkbox"/> Other _____	<input type="checkbox"/> Vasocon <input type="checkbox"/> Opcon <input type="checkbox"/> Naphcon <input type="checkbox"/> Patanol <input type="checkbox"/> Pataday <input type="checkbox"/> Opticrom <input type="checkbox"/> Other _____	

Other Medications:

New medications since last visit:

Do you use a spacer device with your inhaler(s)? Y N

If you use more than one inhaler at a time, which do you use first and why?

Do you use a nebulizer? Y N Date medication cup & tubing changed: _____

Do you use a peak flow meter? Y N What is your "personal best"? _____

Check the box next to the triggers that worsen your asthma, and circle Y or N to indicate whether you have ongoing exposure to the trigger.

- | | | |
|---|---|--|
| <input type="checkbox"/> Respiratory Infection Y N | <input type="checkbox"/> Tobacco smoke Y N | <input type="checkbox"/> Heartburn (GERD) Y N |
| <input type="checkbox"/> Exercise Y N | <input type="checkbox"/> Foods _____ Y N | <input type="checkbox"/> Others _____ Y N |
| <input type="checkbox"/> Weather changes Y N | <input type="checkbox"/> Pets _____ Y N | |
| <input type="checkbox"/> Environmental Irritants Y N | <input type="checkbox"/> Occupational Irritants Y N | |
| <input type="checkbox"/> Dust Y N | <input type="checkbox"/> Emotion/stress/laughter Y N | |
| <input type="checkbox"/> Environmental allergens Y N | <input type="checkbox"/> Drugs _____ Y N | |

Current tobacco smoke exposure (please circle): *Self* *parents* *spouse* *other* *none*

<p>Asthma visits in the past 12 months:</p> <p>Scheduled asthma office visits _____</p> <p>Unscheduled asthma office visits _____</p> <p>Emergency room _____</p> <p>Hospital _____</p> <p style="text-align: right;">Total _____</p> <p>Date of last ER visit for asthma _____</p> <p>Date of last hospitalization for asthma _____</p>	<p>During this office visit would you like to discuss any of the following?</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Asthma goals</td> <td><input type="checkbox"/> Asthma action plan</td> </tr> <tr> <td><input type="checkbox"/> Different treatment options</td> <td><input type="checkbox"/> Depression</td> </tr> <tr> <td><input type="checkbox"/> Different types of medicines</td> <td><input type="checkbox"/> Environmental controls for asthma</td> </tr> <tr> <td><input type="checkbox"/> Side effects of medicines</td> <td><input type="checkbox"/> Use of a spacer</td> </tr> <tr> <td><input type="checkbox"/> Cost of medicines</td> <td><input type="checkbox"/> Use of a peak flow meter</td> </tr> <tr> <td><input type="checkbox"/> Inhaler technique</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Smoking Cessation</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>	<input type="checkbox"/> Asthma goals	<input type="checkbox"/> Asthma action plan	<input type="checkbox"/> Different treatment options	<input type="checkbox"/> Depression	<input type="checkbox"/> Different types of medicines	<input type="checkbox"/> Environmental controls for asthma	<input type="checkbox"/> Side effects of medicines	<input type="checkbox"/> Use of a spacer	<input type="checkbox"/> Cost of medicines	<input type="checkbox"/> Use of a peak flow meter	<input type="checkbox"/> Inhaler technique		<input type="checkbox"/> Smoking Cessation	<input type="checkbox"/> Other: _____
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ASTHMA FOCUSED FOLLOW-UP VISIT

Physician Section

Patient Name: _____

Date: _____

Comorbid disorders/PMHx:

- | | | | |
|---|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Rhinitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Rashes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Conjunctivitis | <input type="checkbox"/> Obesity | <input type="checkbox"/> Oral Allergy Syndrome | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Otitis | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Urticaria | |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Tobacco Abuse | |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Food Allergy | <input type="checkbox"/> Secondhand Smoke | |

Current or previous allergen immunotherapy (dates)

Asthma Medications:

- | | |
|---|---|
| <input type="checkbox"/> Bronchodilator as needed _____ | <input type="checkbox"/> Long-Acting Beta-Agonist _____ |
| <input type="checkbox"/> Bronchodilator daily (short/long acting) _____ | <input type="checkbox"/> Inhaled nasal steroid _____ |
| <input type="checkbox"/> Leukotriene Inhibitor _____ | <input type="checkbox"/> Antihistamine _____ |
| <input type="checkbox"/> Inhaled Steroid for exacerbations _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Inhaled Steroid daily _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Oral Steroid _____ | |

Exam:

Height: _____ HEENT: _____

Weight: _____

Temp: _____ Resp: _____

BP: _____ PF: _____

HR: _____ CV: _____

RR: _____ Skin: _____

Pulse Ox: _____

ASSESSMENT:

Controlled? Yes Partially No

Class: Intermittent Mild persistent Moderate persistent Severe persistent

Risk factors for adverse outcomes:

Patient Education:

<input type="checkbox"/> Uncontrolled asthma <input type="checkbox"/> Severe asthma <input type="checkbox"/> Hospitalization in past two years <input type="checkbox"/> ER visit in past year	<input type="checkbox"/> Nonadherence <input type="checkbox"/> Positive depression screen <input type="checkbox"/> Intubation within past 10 years <input type="checkbox"/> None	<input type="checkbox"/> Asthma Action Plan <input type="checkbox"/> Asthma Goals <input type="checkbox"/> Inhaler technique <input type="checkbox"/> Device training (PFM/Neb/spacer)	<input type="checkbox"/> Medications <input type="checkbox"/> Smoking cessation <input type="checkbox"/> Trigger control <input type="checkbox"/> Other Minutes spent in Education:
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PLAN: Updated Asthma Action Plan

FOLLOW-UP:

Asthma Control	Asthma Control Definition	Suggested Next Visit
Well controlled	ACT score ≥ 20 , no hospitalizations, ER/UC visits, uncontrolled comorbidities; $>50\%$ adherence to controller medication	6 months
Uncontrolled	ACT score ≤ 19 , or unscheduled asthma related care in past year, or adherence to controller $< 50\%$	1-2 months
Asthma uncontrolled on 2 successive visits → consider specialty referral		
Risk factors for adverse outcome & uncontrolled asthma → strongly consider specialty referral		