WISCONSIN ASTHMA COALITION
Children's Health Alliance of Wisconsin

Asthma focused follow-up visit

Patient section

The following should be completed by the primary care provider or primary care nurse. These questions are intended to serve as a guide during your conversation with your patient. Upon completion, this form should be filed in the patient's medical record. *This form should NOT be completed by the patient.*

Patient Name: ________________________ **Date:** _____________ **DOB:** ________ **ACT test score:** ________

Why are you here today?

Current asthma symptoms	Current other symptoms	
☐ Cough	☐ Rash	☐ Muscle pain
☐ Wheeze	☐ Nasal Congestion	☐ Fatigue
☐ Chest tightness	☐ Runny nose/rhinitis	☐ Depression
☐ Short of breath	☐ Sore throat	☐ Headache
☐ Difficulty exercising	☐ Ear pain	☐ Other:
☐ Difficulty breathing at night	☐ Heartburn	
☐ Other:		

Known allergies:
Allergy testing:
Who tested? _________________________ Date: __________________ Result: _____________________
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 (check medications):		
Rescue medicine:	*Controller medicine:*		*Other asthma medications:*	*Pills:*	*Nasal sprays:*	*Eye drops:*
☐ Albuterol	☐ Accolate	☐ Pulmicort	☐ Atrovent	☐ Allegra	☐ Astelin	☐ Naphcon
☐ Proventil	☐ Advair	☐ Qvar	☐ Combivent	☐ Claritin	☐ Flonase	☐ Opcon
☐ Pro-Air	☐ Aerobid	☐ Singulair	☐ Foradil*	☐ Xyzal	☐ Nasonex	☐ Opticrom
☐ Ventolin	☐ Alvesco	☐ Symbicort	☐ Serevent*	☐ Zyrtec	☐ Omnaris	☐ Pataday
☐ Xopenex	☐ Asmanex	☐ Tilade	☐ Spiriva	☐ Other:	☐ Patanase	☐ Patanol
☐ Other:	☐ Flovent	☐ Zyflo	☐ Theophylline		☐ Rhinocort	☐ Vasocon
	☐ Prednisone	☐ Other:	☐ Xolair		☐ Veramyst	☐ Other:
					☐ Other:	
	Dose:		Dose:			

Other medications: **Guidelines recommend Not using as asthma monotherapy*

Do you use a spacer device with your inhaler(s)? Y N
Do you use a nebulizer? Y N
Do you use a peak flow meter? Y N Personal best =

What triggers worsen your asthma (check box) **and do you have ongoing exposure to the trigger** (circle Y N)					
☐ Drugs	Y N	☐ Exercise/Exertion	Y N	☐ Respiratory infection	Y N
☐ Dust	Y N	☐ Foods:	Y N	☐ Tobacco smoke	Y N
☐ Emotion/stress/laughter	Y N	☐ Heartburn (GERD)	Y N	☐ Weather changes	Y N
☐ Environmental allergens	Y N	☐ Occupational irritants	Y N	☐ Others:	Y N
☐ Environmental irritants	Y N	☐ Pets:	Y N		

Current tobacco smoke exposure (please circle): Self Parents Spouse Other None

<u>Asthma</u> visits in the past 12 months	During this office visit would you like to discuss any of the following:	
Scheduled office visits: ______	☐ Asthma goals	☐ Asthma action plan
Unscheduled office visits: ______	☐ Different treatment options	☐ Depression
Emergency room: ______	☐ Different types of medicines	☐ Environmental controls for asthma
Hospital: ______	☐ Side effects of medicines	☐ Use of a spacer
TOTAL: ______	☐ Cost of medicines	☐ Use of a peak flow meter
Date of last ER visit: _______________	☐ Inhaler technique	☐ Other:
Date of last hospitalization: ___________	☐ Smoking cessation	
Ever been on a ventilator? Y N		

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Primary care provider section

Patient name: _______________________________ Date: _____________________

Comorbid disorders/PMHx			
☐ Conjunctivitis	☐ Obesity	☐ Rashes	☐ Sleep apnea
☐ Diabetes	☐ Oral allergy syndrome	☐ Rhinitis	☐ Tobacco abuse
☐ Eczema	☐ Otitis	☐ Secondhand smoke	☐ Urticaria
☐ Food allergy	☐ Pregnancy	☐ Sinusitis	☐ Other:
☐ GERD			

Current or previous allergen immunotherapy: Dates:

Exam	
Height:	HEENT:
Weight:	
Temp:	Pulse Ox:
BP:	Resp:
HR:	CV:
RR:	Skin:

DIAGNOSTIC DATA:
Spirometry: FEV1: FVC: FEV1/FVC%: FEF 25-75%:
Peak Flow:

ASSESSMENT:
Control: Well controlled Not-well controlled Very poorly controlled
Class (determined at initial asthma visit): Intermittent Mild persistent Moderate persistent Severe persistent

Asthma medications to be prescribed	
Bronchodilator as needed: ___________________________	Long-acting beta-agonist: ____________________________
Bronchodilator daily (short/long acting): _______________	Inhaled nasal steroid: ________________________________
Leukotriene modifier: _______________________________	Antihistamine: ______________________________________
Inhaled steroid for exacerbations: ____________________	Other: ____
Inhaled steroid daily: ______________________________	Other: ____
Oral steroid: ______________________________________	

Risk factors for adverse outcomes		Patient education	
☐ Uncontrolled asthma	☐ Non-adherence	☐ Asthma action plan	☐ Medications
☐ Severe asthma	☐ Positive depression screen	☐ Asthma goals	☐ Smoking cessation
☐ Hospitalization in past two years	☐ Intubation within past 10 years	☐ Device training (PFM/Neb/spacer)	☐ Trigger control
☐ ER visit in past year	☐ Psychiatric co-morbidities	☐ Inhaler technique	☐ Other:
	☐ None		**Minutes spent in education:**

Reasons for non-adherence:

PLAN:
☐ Updated asthma action plan

FOLLOW-UP:

Asthma control	Asthma control definition	Next visit
Well controlled	ACT score ≥ 20, no hospitalizations, ER/UC visits, uncontrolled comorbidities; > 50% adherence to controller medication	
Uncontrolled	ACT score ≤ 19, or unscheduled asthma related care in past year, or adherence to controller < 50%	*1-2 months recommended*
Asthma uncontrolled on two consecutive visits → consider specialty referral		
Risk factors for adverse outcome and uncontrolled asthma → strongly consider specialty referral		

Provider Signature: ___________________________________ Date: _________________ Time: _____________

Provider Signature: ____________________________________ Date: ___________________ Time: _____________