



## Asthma Visit

Name  
Room  
CC

Weight	T	Peak Flow	
Height	HR	Zone	G Y R
	RR	ACT Score	
	O2		

Do you have asthma symptoms today?	No	Yes
Do you need medication refills?	No	Yes
Do you need forms filled out today?	No	Yes

Last Albuterol use?	Days/Weeks/Months Ago
Do you use albuterol every week?	No Yes
Have you used a controller medicine in the past (Qvar/Flovent/Pulmicort)?	No Yes
Do you use controller medicine (Qvar/Flovent/Pulmicort) daily?	Yes No
Do you cough with exercise?	No Yes
Do you cough at night or early morning?	No Yes
Do you cough with laughter?	No Yes

In the last 3 months:

Has your child missed school due to asthma?	No	Yes
Have parents missed work due to child's asthma?	No	Yes
Visited urgent care or ER due to asthma?	No	Yes

Asthma Triggers

Weather	No	Yes
Colds	No	Yes
Allergies	No	Yes
Smoke/Dust	No	Yes
Pets	No	Yes
Exercise	No	Yes

Further Studies

CXR  
Referral

Followup	D/W/M
Reason	

EHR