

ASTHMA VISIT DOCUMENTATION FORM

Name: _____ Date: _____
 History number: _____ Peak flow personal best: _____

CLASSIFICATION (circle appropriate category)

	1: Mild intermittent	2: Mild persistent	3: Moderate persistent	4: Severe persistent
Quick-acting medication	≤ 2 times/week	3 to 6 times/week	Daily	All the time
Night-time waking	≤ 2 times/month	3 to 4 times/month	≥ 5 times/month	Frequent
Symptoms interference	None unless with attack	Only with lots of activity	Only with moderate activity	With any activity
FEV ₁ , PEF (% pred.)	≥ 80 percent	≥ 80 percent	> 60 percent, < 80 percent	≤ 60 percent

Type of visit: Acute / Follow-up / Educational Triggers: _____
 BP: _____ Social issues: _____
 Ht/Wt: _____
 Pulse: _____ O₂ Sat: _____
 RR: _____ Tobacco exposure: _____
 Days with Sx (#/wk): _____ ED since last visit? Y N Dates: _____
 Current severity score: 1 2 3 4 Hospitalizations since last visit? Y N Dates: _____

Bronchodilator: _____
 Controller: _____ Other: _____
 Peak flow: Pre: _____ Post: _____ Triggers this visit: _____
 History: _____

Pertinent ROS: Derm: _____ GI: _____ ENT: _____ Other: _____
 Physical exam: HNT: _____
 CV: _____
 Pulm: _____ Wheezes: _____
 GI: _____ I:E _____
 Other: _____

Treatment notes: _____

Assessment: 1. Asthma _____
 2. _____
 3. _____
 Plan: 1. _____
 2. _____
 3. _____

TEACHING

Review / Update

Review / Update

Action plan/education: _____ Trigger avoidance/coping: _____
 Smoke/environment: _____ Controller meds: _____
 Peak flow: _____ What asthma is: _____
 Use of MDI/spacer/neb: _____ Exercise: _____
 Other: _____ School/work issues: _____
 Planned follow-up: _____
 _____ MD/PA/NP: _____



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