

ASTHMA CHECKLIST

DOB:

NAME:

INDICATORS:				
Type of Visit:	<input type="checkbox"/> Acute Care <input type="checkbox"/> Well Ck <input type="checkbox"/> FU ER/hospital	<input type="checkbox"/> Acute Care <input type="checkbox"/> Well Ck <input type="checkbox"/> FU ER/hospital	<input type="checkbox"/> Acute Care <input type="checkbox"/> Well Ck <input type="checkbox"/> FU ER/hospital	<input type="checkbox"/> Acute Care <input type="checkbox"/> Well Ck <input type="checkbox"/> FU ER/hospital
Asthma Severity	<input type="checkbox"/> MI <input type="checkbox"/> MP <input type="checkbox"/> ModP <input type="checkbox"/> SP	<input type="checkbox"/> MI <input type="checkbox"/> MP <input type="checkbox"/> ModP <input type="checkbox"/> SP	<input type="checkbox"/> MI <input type="checkbox"/> MP <input type="checkbox"/> ModP <input type="checkbox"/> SP	<input type="checkbox"/> MI <input type="checkbox"/> MP <input type="checkbox"/> ModP <input type="checkbox"/> SP
Sx since last visit	<input type="checkbox"/> Cough <input type="checkbox"/> Whze <input type="checkbox"/> SOB <input type="checkbox"/> Chs. Tight <input type="checkbox"/> None I/C	<input type="checkbox"/> Cough <input type="checkbox"/> Whze <input type="checkbox"/> SOB <input type="checkbox"/> Chs. Tight <input type="checkbox"/> None I/C	<input type="checkbox"/> Cough <input type="checkbox"/> Whze <input type="checkbox"/> SOB <input type="checkbox"/> Chs. Tight <input type="checkbox"/> None I/C	<input type="checkbox"/> Cough <input type="checkbox"/> Whze <input type="checkbox"/> SOB <input type="checkbox"/> Chs. Tight <input type="checkbox"/> None I/C
Recent Day Sx	<input type="checkbox"/> 0 times/week <input type="checkbox"/> Daily <input type="checkbox"/> 1-2 times/week <input type="checkbox"/> Continual <input type="checkbox"/> >2 times/week	<input type="checkbox"/> 0 times/week <input type="checkbox"/> Daily <input type="checkbox"/> 1-2 times/week <input type="checkbox"/> Continual <input type="checkbox"/> >2 times/week	<input type="checkbox"/> 0 times/week <input type="checkbox"/> Daily <input type="checkbox"/> 1-2 times/week <input type="checkbox"/> Continual <input type="checkbox"/> >2 times/week	<input type="checkbox"/> 0 times/week <input type="checkbox"/> Daily <input type="checkbox"/> 1-2 times/week <input type="checkbox"/> Continual <input type="checkbox"/> >2 times/week
Recent Night Sx.	<input type="checkbox"/> 0 times/mos <input type="checkbox"/> 3-4 times/mos <input type="checkbox"/> 1-2 times/mos <input type="checkbox"/> >4 times/mos	<input type="checkbox"/> 0 times/mos <input type="checkbox"/> 3-4 times/mos <input type="checkbox"/> 1-2 times/mos <input type="checkbox"/> >4 times/mos	<input type="checkbox"/> 0 times/mos <input type="checkbox"/> 3-4 times/mos <input type="checkbox"/> 1-2 times/mos <input type="checkbox"/> >4 times/mos	<input type="checkbox"/> 0 times/mos <input type="checkbox"/> 3-4 times/mos <input type="checkbox"/> 1-2 times/mos <input type="checkbox"/> >4 times/mos
# Exac/Last Visit				
ER/Hospital				
Albuterol use/wk				
Absent Days	<input type="checkbox"/> School <input type="checkbox"/> Work	<input type="checkbox"/> School <input type="checkbox"/> Work	<input type="checkbox"/> School <input type="checkbox"/> Work	<input type="checkbox"/> School <input type="checkbox"/> Work
Impact on Actvty	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
PFM Reading	<input type="checkbox"/> Personal Best	<input type="checkbox"/> Personal Best	<input type="checkbox"/> Personal Best	<input type="checkbox"/> Personal Best
Day of Visit	<input type="checkbox"/> Today's PF	<input type="checkbox"/> Today's PF	<input type="checkbox"/> Today's PF	<input type="checkbox"/> Today's PF
Skills/Taught Reviewed	<input type="checkbox"/> Inhaler/Spacer Use <input type="checkbox"/> PFM/Sx monitoring <input type="checkbox"/> Trigger Rcg'n & Redctn <input type="checkbox"/> recg. of Med/Refill	<input type="checkbox"/> Inhaler/Spacer Use <input type="checkbox"/> PFM/Sx monitoring <input type="checkbox"/> Trigger Rcg'n & Redctn <input type="checkbox"/> recg. of Med/Refill	<input type="checkbox"/> Inhaler/Spacer Use <input type="checkbox"/> PFM/Sx monitoring <input type="checkbox"/> Trigger Rcg'n & Redctn <input type="checkbox"/> recg. of Med/Refill	<input type="checkbox"/> Inhaler/Spacer Use <input type="checkbox"/> PFM/Sx monitoring <input type="checkbox"/> Trigger Rcg'n & Redctn <input type="checkbox"/> recg. of Med/Refill
Asthma Action Plan	<input type="checkbox"/> Created <input type="checkbox"/> Revised <input type="checkbox"/> Reviewed <input type="checkbox"/> NA	<input type="checkbox"/> Created <input type="checkbox"/> Revised <input type="checkbox"/> Reviewed <input type="checkbox"/> NA	<input type="checkbox"/> Created <input type="checkbox"/> Revised <input type="checkbox"/> Reviewed <input type="checkbox"/> NA	<input type="checkbox"/> Created <input type="checkbox"/> Revised <input type="checkbox"/> Reviewed <input type="checkbox"/> NA
Devices at Home	<input type="checkbox"/> Neb <input type="checkbox"/> Spacer <input type="checkbox"/> PFM <input type="checkbox"/> Sp Mask <input type="checkbox"/> Nothing	<input type="checkbox"/> Neb <input type="checkbox"/> Spacer <input type="checkbox"/> PFM <input type="checkbox"/> Sp Mask <input type="checkbox"/> Nothing	<input type="checkbox"/> Neb <input type="checkbox"/> Spacer <input type="checkbox"/> PFM <input type="checkbox"/> Sp Mask <input type="checkbox"/> Nothing	<input type="checkbox"/> Neb <input type="checkbox"/> Spacer <input type="checkbox"/> PFM <input type="checkbox"/> Sp Mask <input type="checkbox"/> Nothing
Med Changes				
Refill Needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alb/spc @ sch?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Triggers ID'd	<input type="checkbox"/> Smoking <input type="checkbox"/> Roaches <input type="checkbox"/> Dust <input type="checkbox"/> Pets <input type="checkbox"/> Pollution <input type="checkbox"/> Handouts Given	<input type="checkbox"/> Smoking <input type="checkbox"/> Roaches <input type="checkbox"/> Dust <input type="checkbox"/> Pets <input type="checkbox"/> Pollution <input type="checkbox"/> Handouts Given	<input type="checkbox"/> Smoking <input type="checkbox"/> Roaches <input type="checkbox"/> Dust <input type="checkbox"/> Pets <input type="checkbox"/> Pollution <input type="checkbox"/> Handouts Given	<input type="checkbox"/> Smoking <input type="checkbox"/> Roaches <input type="checkbox"/> Dust <input type="checkbox"/> Pets <input type="checkbox"/> Pollution <input type="checkbox"/> Handouts Given
Flu Shot Given?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Referral?	<input type="checkbox"/> AST/PFT Clinic Date of AST/PFT: _____ <input type="checkbox"/> Allergist <input type="checkbox"/> Asthma Program <input type="checkbox"/> Other _____	<input type="checkbox"/> AST/PFT Clinic Date of AST/PFT: _____ <input type="checkbox"/> Allergist <input type="checkbox"/> Asthma Program <input type="checkbox"/> Other _____	<input type="checkbox"/> AST/PFT Clinic Date of AST/PFT: _____ <input type="checkbox"/> Allergist <input type="checkbox"/> Asthma Program <input type="checkbox"/> Other _____	<input type="checkbox"/> AST/PFT Clinic Date of AST/PFT: _____ <input type="checkbox"/> Allergist <input type="checkbox"/> Asthma Program <input type="checkbox"/> Other _____
MD/NP Initials				
Date:				

Created at The Children's Clinic (562) 933-0400