Name: FMP/SSN last four: DOB:

Appointment Date: Contact Number:

PEDIATRIC ASTHMA VISIT

Do you have any concerns today? _____

Are your child's asthma symptoms stable, improved or worsening? _____

Any recent ER visits? ❑Yes ❑ No **When:** _____ **Reason:**_____

********(Please complete information below: If filled out before, list only changes since the last visit.)********

Chronic Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
Hay fever/Allergies **Asthma** **ADHD** **Overweight** **Chronic ear infections** **Other:**		**Hay fever/Allergies** **Asthma** **Sudden death** **Heart attack <50** **Other:**	**Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):** Does your child ever forget to take their medications? ❑ Yes ❑ No

Please list any known **allergies** your child has (drug, food, latex) _____

Is your child enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? ❑ Yes ❑ No

Is the child's sponsor currently deployed? ❑Yes ❑ No Is this visit **deployment** related? ❑Yes ❑ No

Are either of the child's parents on PRP status? ❑Yes ❑ No

Are your child's immunizations up to date? ❑ Yes ❑ No ❑ Unsure **Flu shot this season?** ❑ Yes ❑ No

Who does your child live with? _____

Does your child attend: ❑ DOD school ❑ British school ❑ Home-school Grade? ____ ❑ Aftercare **Any Concerns?** ❑ Yes ❑ No

Does anyone in the family smoke? ❑ Yes ❑ No

Would you say your child's overall health is: ❑ Excellent / Very Good / Good ❑ Fair / Poor

Do you & your child feel safe at home? ❑ Yes ❑ No

What is your preferred method for learning: ❑ Verbal ❑ Written ❑ Visual ❑ Other: _____

Preferred language: ❑ English ❑ Other: _____

Are there cultural or religious considerations that affect your child's healthcare? ❑ Yes ❑ No _____

In the PAST MONTH, has your child had any of the following due to their asthma:

Exercise induced cough/wheeze?	Yes/No	Frequency?___	Daytime cough?	Yes/No	Frequency?_____
Missed school?	Yes/No	Frequency?_____	Runny nose?	Yes/No	Frequency?_____
Wheezing?	Yes/No	Frequency?_____	Nasal congestion?	Yes/No	Frequency?_____
Wheezing with a cold?	Yes/No	Frequency?_____	Trouble breathing?	Yes/No	Frequency?_____
Cough at night?	Yes/No	Frequency?_____	Other (describe)		_____

Circle if your child has/had: Born preterm/Eczema/Hay fever,Allergies/ Bronchiolitis/Pneumonia/Reflux/Ear infection

When was your child diagnosed with asthma? _____

How many times was your child hospitalized for asthma in the past 5 years? _____

Has your child ever been admitted to the ICU? ❑ Yes ❑ No **If so, ever been intubated**? ❑ Yes ❑ No ❑ Unsure

How many times has your child been seen in the Emergency Department in the PAST YEAR for asthma?_____

How many times has your child taken oral steroids (Prelone, prednisone, etc) in the PAST YEAR? _____

When was the last time your child used albuterol or xopenex? _____

If your child is over 5 years old, have they had pulmonary function testing? ❑ Yes ❑ No When? _____

Does your child have an asthma action plan? ❑ Yes ❑ No ❑ Unsure

Does your child use a spacer with their inhaler? ❑ Yes ❑ No

Does your child have a rescue inhaler (Albuterol/ Xopenex) AND spacer at school/daycare? ❑ Yes ❑ No

Have you/your child attended Asthma Education in past year ? ❑ Yes ❑ No When?_____

Circle what triggers his/her asthma? Exercise/common cold/tobacco smoke/cold weather/hayfever or allergies

Other: _____

Wt		HR		PF	Pain: ❑ Yes ❑ No Location of Pain _____
Ht		RR			
BMI/%		SpO2		Expected	Imm UTD per ASIMS: ❑ Yes ❑ No Technician Signature:_____
Temp		BP			

HPI:

NE	Examination:	Normal	Abnormal
□	**General:**	□ Active/Alert/WN/WD/NAD	□
□	**Head/Neck:**	□ NCAT/non-tender/FROM	□
□	**Eyes:**	□ Clear, no injection, no D/C	□
□	**R ear:**	□ TM gray/mobile	□ Bulging/immobile/red
□	**L ear:**	□ TM gray/mobile	□ Bulging/immobile/red
□	**Nose:**	□ No congestion/discharge	□ Congested
□	**Oropharynx:**	□ Pink, moist, no lesions	□
□	**Lungs:**	□ CTAB, no retractions, nl WOB	□
□	**CV:**	□ RRR s Murmur, strong pulses, cap refill < 2 sec	□
□	**Abd:**	□ Soft, NT, no HSM, no masses, nl BS	□
□	**Ext:**	□ NL, FROM, nontender, no edema	□
□	**Skin:**	□ No rash	□
□	**Lymph:**	□ No adenopathy	□
□	**Other:**	□	□

ASSESSMENT: **Asthma: Intermittent, Mild Persistent, Moderate Persistent, Severe Persistent**
□ Controlled □ Uncontrolled

PLAN:

Asthma Action Plan Reviewed? □ Yes, copy given to patient □ No
□ Asthma Education (Annually)

PFTs ordered? □ Yes □ No □ N/A
(at least annually)

F/U:
□ F/U sooner if increased inhaler use, worsening sx, or parental concern
□ Patient and/or parent verbalizes understanding of treatment and plan

PREVENTION: ☐ Hand washing ☐ Annual Flu Shot ☐ Smoking cessation ☐ Avoidance of Triggers
☐ Exercise ☐ Nutrition ☐ Media Time

Signature:_____
Date:
Stamp:

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RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

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