

# OBCC Asthma Visit Planner

Data Entry Note:

**Date:**      /      /

**Well Child Check** (last 12 m)    ☐ Yes    ☐ No

**Type of Visit**    ☐ Acute    ☐ Planned

**Family Situation**    ☐ Foster    ☐ Kinship    ☐ Homeless    ☐ Adopted    ☐ Parents

TEMPERATURE	PULSE	BMI	BMI ASSESSMENT <input type="checkbox"/> Under Wt (<5%) <input type="checkbox"/> Healthy Wt (5-84%) <input type="checkbox"/> At Risk (85-94%) <input type="checkbox"/> Overweight (≥95%)
WEIGHT	HEIGHT	BP	

**HISTORY**

Concerns and questions

**ER Visits (Dates in last six mos)**

**Hospitalizations (dates in last 6 m)**

**# Days of Daycare/School Missed (last 3 m)**

**# Oral Steroid Bursts (last 6 m)**

**Asthma Symptoms** \_\_\_\_\_ Days/Wk  
Nights/Wk

**Albuterol Use** \_\_\_\_\_ Days/Wk

**SPIROMETRY**

PRE	POST
FEV 1 -- % PREDICTED	
FEV1/FVC	
FEF 25 - 75 %PREDICTED	
PEFR -- % PREDICTED	

**MEDICATIONS**

Short-Acting Beta Agonist

Inhaled Corticosteroid

Leukotriene Modifier

Combination Inhaled Product

Other

**REFERRALS**

☐ PH Home Visit

☐ ENT    ☐ Pulmonary    ☐ Allergy    ☐ Other \_\_\_\_\_

Care Coordination needed?

☐ Yes    ☐ No

**CO-MORBIDITIES**

☐ (Enter condition name or ICD-9 code)

\_\_\_\_\_

**PHYSICAL EXAMINATION**

☒ =NL

<input type="checkbox"/> GENERAL APPEARANCE	<input type="checkbox"/> GENITALIA
<input type="checkbox"/> HEAD	<input type="checkbox"/> MALE/TESTES DOWN
<input type="checkbox"/> EYES	Tanner stage
<input type="checkbox"/> EARS	<input type="checkbox"/> FEMALE
<input type="checkbox"/> NOSE	Tanner stage
<input type="checkbox"/> MOUTH AND THROAT	<input type="checkbox"/> EXTREMITIES
<input type="checkbox"/> NECK	<input type="checkbox"/> BACK
<input type="checkbox"/> TEETH	<input type="checkbox"/> SKIN
<input type="checkbox"/> BREASTS (female)	<input type="checkbox"/> No striae/hirsutism
Tanner stage	<input type="checkbox"/> No acanthosis nigricans
<input type="checkbox"/> LUNGS	<input type="checkbox"/> NEUROLOGIC
<input type="checkbox"/> HEART	
<input type="checkbox"/> ADBOMEN	
<input type="checkbox"/> VISION _____	
<input type="checkbox"/> HEARING _____	

Abnormal findings and comments

**IMPRESSION AND PLAN**

**ETS Exposure** (Environmental Tobacco Smoke)    ☐ Yes    ☐ No

**Allergy Triggers**    ☐ Grasses    ☐ Trees    ☐ Animal Dander    ☐ Cockroaches    ☐ Dust Mites    ☐ Mold

**Asthma Severity Assessment**    ☐ Intermittent    ☐ Mild Persistent    ☐ Moderate Persistent    ☐ Severe Persistent

**Asthma Control Assessment**    ☐ Well Controlled    ☐ Not Well Controlled    ☐ Very Poorly Controlled

**Education**    ☐ MDI/Spacer Use    ☐ Pathophysiology    ☐ Medications    ☐ Triggers/Allergens/Control    ☐ Peak Flow/Monitoring    ☐ ETS

**Mitigation Strategy Reviewed**    ☐ Grasses    ☐ Trees    ☐ Animal Dander    ☐ Cockroaches    ☐ Dust Mites    ☐ Mold    ☐ ETS

**School Care Plan**    ☐ In Place    ☐ NA

**Management Plan Reviewed/Updated**    ☐ Yes    ☐ No

**Flu Shot**    ☐ Yes    ☐ No    ☐ NA

**Follow-up/Next Visit in**     wks/mos with    ☐ Provider \_\_\_\_\_

**Signature:** \_\_\_\_\_



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Place Label Here

Patient Name:  
MR #:  
DOB: