LeBonheur SM
Children's Medical Center

PEDIATRIC HISTORY AND PHYSICAL STATUS ASTHMATICUS
(for use by Residents)

HPI: _____ year old M F with a known history of asthma presents with _____ hour / day history of increased work of breathing associated with the following other symptoms (circle all that apply)

Cough Fever to _____ URI Vomiting Diarrhea Chest Pain Dyspnea

Exposure to known triggers (what and when): _____

Other symptoms / HPI _____

_____

_____

Therapy received at home before presentation was _____

Therapy received in ED / physician's office was:

☐ Albuterol short treatment X _____ ☐ Ipratropium X _____ ☐ Prednisone _____ mg PO

☐ Albuterol long treatment X _____ ☐ EpinephrineX _____ ☐ Other _____

☐ Albuterol MDI treatment X _____ ☐ Methylprednisolone _____ mg IWPO ☐ Other _____

Asthma History:

Age at diagnosis _____ mos / yrs Age first wheeze _____ mos / yrs

Known triggers: _____

Allergies: _____

Exposure to: Smokers in home ☐ YES ☐ NO Indoor pets ☐ YES ☐ NO Carpet ☐ YES ☐ NO

Baseline Asthma: Assessment of Symptom Frequency / Severity:

Frequency of wheezing _____ X week / month / year

Nighttime cough _____ X week / month

Nighttime awakenings _____ X week / month

Exercise induced symptoms ☐ YES ☐ NO

Last episode of wheezing was _____ days / weeks / months / years ago

Number of school days missed past year_____ Number of these related to asthma _____

Unscheduled visits for asthma past year: PCP _____ ED _____ Last ED visit _____

Number of previous admissions for asthma _____ Last admission _____

Number of ICU admissions _____ Ever intubated: ☐ YES ☐ NO Last ICU admission _____

Seen by asthma specialist? ☐ YES ☐ NO Who? _____ Last visit _____

Home Treatment / Evaluation:

Current home medication routine:

Drug	Dose	Frequency	Adherent
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO

Other medications used in past _____ When _____

_____ When _____

Has home nebulizer: ☐ YES ☐ NO

Has peakflow meter: ☐ YES ☐ NO If yes: Keeps diary? ☐ YES ☐ NO Personal best _____

Type of spacer device used: _____

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PEDIATRIC HISTORY AND PHYSICAL STATUS ASTHMATICUS
(for use by Residents) (continued)

Previous Medical / Surgical History (Other Than Asthma):

_____

Immunizations: UTD history UTD verified DELAYED UNKNOWN **Influenza vaccine this season:** ☐ YES ☐ NO

Primary Medical Care Provider: _____

Development: ☐ Appropriate for age
☐ Delayed _____

Family History:

Relatives with asthma / atopy: _____

Other family history: _____

Social History:

_____

_____

Review of Systems:

	NI	Abnl			NI	Abnl	
Constitutional	☐	☐	_____	All/Immuno	☐	☐	_____
Eyes	☐	☐	_____	GU	☐	☐	_____
ENT mouth	☐	☐	_____	CV	☐	☐	_____
Musculoskeletal	☐	☐	_____	Resp	☐	☐	_____
Skin	☐	☐	_____	GI	☐	☐	_____
Neuro	☐	☐	_____	Psych	☐	☐	_____
Heme/lymph	☐	☐	_____	Endo	☐	☐	_____

Physical Exam:

Temp _____ **HR** _____ **RR** _____ **BP** _____ **SpO_2** _____ **FiO_2** _____

Wt _____ kg **% ile** _____ **Ht** _____ cm **% ile** _____ **HC** _____ cm **% ile** _____

General apperance _____

Lung/Chest Exam: _____

Asthma Severity Assessment: RDAI score _____ % Predicted Peak Flow _____ O_2 Requirement _____

	NI	Abnl			NI	Abnl	
Head	☐	☐	_____	Extremities	☐	☐	_____
Skin	☐	☐	_____	Heart	☐	☐	_____
Eyes	☐	☐	_____	Pulses	☐	☐	_____
Ears	☐	☐	_____	Perfusion	☐	☐	_____
Nose	☐	☐	_____	Abdomen	☐	☐	_____
Mouth	☐	☐	_____	Neurologic	☐	☐	_____
Neck	☐	☐	_____	Genitals	☐	☐	_____

Other abnormal findings _____

_____

_____

Labs: **CXR:**

LeBonheur Children's Medical Center

PEDIATRIC HISTORY AND PHYSICAL STATUS ASTHMATICUS
(for use by Residents)

Assessment: Known asthmatic with status asthmaticus

Patient ☐ IS ☐ IS NOT considered High Risk

Severity of Asthma Exacerbation: ☐ Mild
☐ Moderate
☐ Severe

Baseline Asthma Assessment:

☐ Mild Intermittent Asthma	☐ Mild Persistent Asthma	☐ Moderate Persistent Asthma	☐ Severe Asthma
Symptoms < 2/week	Symptoms > 2/week	Daily symptoms	Continual Symptoms
Nighttime symptoms < 2/mo	Nighttime Symptoms > 2/mo	Nighttime Symptoms > 1/week	Frequent Nighttime Symptoms
Lung Function ≥ 80% Predicted	Lung Function ≥ 80% Predicted	Lung Function > 60%-≤ 80% Predicted	Lung Function ≤ 60% Predicted

Consider classifying patient as a persistent asthmatic if they have had greater than 2 ED visits or hospitalizations in the past year, or if they have used more than two canisters of albuterol in past year.

Assessment of current home medication regimen:

☐ Asthma generally well controlled, medications appropriate
☐ Asthma poorly controlled, needs additional controller therapy
☐ Patient is persistent asthmatic. Inhaled corticosteroids to be initiated/continued
☐ Lack of compliance w/prescribed regimen

Other suspected/known diagnoses:

_____

_____

_____

Plan/Meds: Admit for continued assessment and treatment of status asthmaticus

☐ Assess and treat acute asthma per Asthma Guidelines
☐ Assess and treat acute asthma per specified orders

☐ Modification of home controller therapy is indicated and will consist of:

_____

_____

☐ Continue home controller therapy of:

_____

_____

☐ Other plans and medications:

_____

_____

Date: _____ Time: _____ Resident Signature: _____ MD # _____

Printed Name: _____

I have examined the patient, read and reviewed this History and Physical with the house staff, and verified the information with the parent/guardian. I agree with this history, physical, assessment and plan except as stated.

_____

_____

_____

Attending: _____ MD # _____ Date: _____ Time: _____