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:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
<th>Adherent</th>
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<td>□ YES □ NO</td>
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</table>

Other medications used in past

Has home nebulizer: □ YES □ NO

Has peakflow meter: □ YES □ NO  If yes: Keeps diary? □ YES □ NO  Personal best __________________________}

Type of spacer device used: ________________________________________________________________
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:

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<thead>
<tr>
<th>System</th>
<th>NI</th>
<th>Abnl</th>
<th>All/Immuno</th>
<th>CV</th>
<th>GI</th>
<th>Resp</th>
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Physical Exam:

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<tr>
<th>Parameter</th>
<th>Value</th>
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<tr>
<td>Temp</td>
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<td>HR</td>
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<td>FiO2</td>
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Wt ________ kg  % ile ________  Ht ________ cm  % ile ________  HC ________ cm  % ile ________

General appearance ________________________________________________________________

Lung/Chest Exam: ________________________________________________________________

Asthma Severity Assessment: RDAI score ________  % Predicted Peak Flow ________  O2 Requirement ________

<table>
<thead>
<tr>
<th>Site</th>
<th>NI</th>
<th>Abnl</th>
<th>Extremities</th>
<th>Heart</th>
<th>Pulses</th>
<th>Perfusion</th>
<th>Abdomen</th>
<th>Neurologic</th>
<th>Genitals</th>
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Other abnormal findings _____________________________________________________________

Labs:  CXR:
**Assessment:** Known asthmatic with status asthmaticus

Patient □ IS □ IS NOT considered High Risk

Severity of Asthma Exacerbation: □ Mild  □ Moderate  □ Severe

**Baseline Asthma Assessment:**

<table>
<thead>
<tr>
<th>Mild Intermittent Asthma</th>
<th>Mild Persistent Asthma</th>
<th>Moderate Persistent Asthma</th>
<th>Severe Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms &lt; 2/week</td>
<td>Symptoms &gt; 2/week</td>
<td>Daily symptoms</td>
<td>Continual Symptoms</td>
</tr>
<tr>
<td>Nighttime symptoms &lt; 2/mo</td>
<td>Nighttime Symptoms &gt; 2/mo</td>
<td>Nighttime Symptoms &gt; 1/week</td>
<td>Frequent Nighttime Symptoms</td>
</tr>
<tr>
<td>Lung Function ≥ 80% Predicted</td>
<td>Lung Function &gt; 80% Predicted</td>
<td>Lung Function &gt; 60%-&lt; 80% Predicted</td>
<td>Lung Function ≤ 60% Predicted</td>
</tr>
</tbody>
</table>

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: ________