

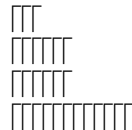
Asthma Flow Sheet

Patient's Name: _____ History Number _____
 Classification: _____ Best Peak Flow _____

Date						
Current Severity (MildInt, MildPers, ModPers, Sev Pers)						
Handouts Given <input type="checkbox"/> Triggers <input type="checkbox"/> Medications <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____						
Triggers: <input type="checkbox"/> Environ. <input type="checkbox"/> Stress <input type="checkbox"/> Pets <input type="checkbox"/> Odors/ Perfumes <input type="checkbox"/> Smoking <input type="checkbox"/> Dust <input type="checkbox"/> Pollens <input type="checkbox"/> Other						
Medication Review <input type="checkbox"/> Controllers <input type="checkbox"/> Quick Relief						
Peak Flow Review/Best						
Delivery Device Tech. Review						
Flu Shot						
Asthma Plan <input type="checkbox"/> Made <input type="checkbox"/> Updated <input type="checkbox"/> Provided to School						
Symptom Free Days _____ Days Lost Work/School _____						
Provider Initials						

Schedule for Office Visits:

Severe persistent
 Moderate persistent
 Mild persistent
 Mild intermittent



every 3 months
 every 6 months
 every 6 months
 every 12 months

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 Durham Pediatrics, at
www.HealthDisparities.net;
 Modified: Kurt Elward, MD,
 AAFP ,2003

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