Patient Name: _____ **Age:** _____

Asthma Visit Date: _____ **Male / Female** **Medical Record #:** _____

SOAP NOTE FOR ASTHMA

SUBJECTIVE DATA

How many days per week or how many times per day do you have asthma symptoms? *per week* *per day*

How many nights per week or per month do you wake up because of asthma symptoms? *per week* *per month*

How often do you use your rescue inhaler for these symptoms?

Do any of these symptoms interfere with your: ☐ work ☐ school ☐ exercise/activities
How much does it interfere? ☐ minor ☐ some ☐ extreme

Have you visited an emergency room, urgent care office, been admitted to the hospital, or received oral corticosteroids for treatment of asthma since your last visit? ☐ Yes ☐ No

Asthma Control Test™, Asthma Control Questionnaire (ACQ), or Asthma Therapy Assessment Questionnaire (ATAQ) score:

Daily preventive asthma med:	Rescue med:
Concurrent meds:	Other treatments:

Approximately what % of time is patient taking his/her medicines? ☐ 100% ☐ 75% ☐ 50% ☐ less than 25%

Comorbidities: ☐ Allergic rhinitis ☐ COPD ☐ Sinusitis ☐ GERD ☐ Eczema ☐ Obesity ☐ Diabetes ☐ Food allergy
Other:

OBJECTIVE DATA

Respiratory Assessment		Vitals	Physical Examination
Tobacco use:		Temp:	HEENT:
Today's peak flow:		HR:	Lungs:
PulseOx pre-med:	Post-med:	RR:	Heart:
Labs:		BP:	Abdomen:
Radiology:		HT:	Extremities:
Spirometry:		WT:	Neuro:

ASSESSMENT

Classification of Severity: Assess at initial presentation of patients not currently taking a daily preventive asthma medicine:
☐ Severe persistent ☐ Moderate persistent ☐ Mild persistent ☐ Intermittent

Classification of Control: ☐ Well controlled ☐ Not well controlled ☐ Very poorly controlled

Is current therapy achieving adequate control? ☐ Yes ☐ No *If no, action taken*:

Inhaler technique: ☐ Satisfactory ☐ Unsatisfactory ☐ Training demo provided

PLAN

☐ Provide self-management education, asthma action plan ☐ Review/update asthma action plan
☐ Recommend measures to control exposure to allergens and pollutants or irritants that make asthma worse
☐ Treat comorbid conditions ☐ Influenza vaccine ☐ Other vaccines
☐ Tests to be ordered:
☐ Medications:
☐ Next visit:

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Provider Name (printed): _____ Signature: _____