McLAREN AMBULATORY CARE CENTER
PERSISTENT ASTHMA MANAGEMENT

Smoker: ☐ **Yes** ☐ **No** Date Ceased: _____

2nd Hand exposure ☐ Yes ☐ No

Each Visit (Date)									
Asthma Education									
Smoking Education/Rx									
Peak Flow Meter									

Annual Tests (Date)									
Action Plan									
Spirometry									

Medications									
Rescue Meds:									
B-Agonist									
Controller Meds:									
Inhaled Corticosteroid									
Other:									

Miscellaneous (Date)									
Flu Vaccine									
Pneumonia Vaccine									
Pulmonary Referral									

Referrals/Comments: _____

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PATIENT NAME:

DATE OF BIRTH: