Asthma Evaluation SOAP Note

(Adults and youths ≥12 years of age)

S:	[Subjective] Patient report of symptoms as described by the patient
O:	[Objective] Vitals signs, physical examination findings, lab test results, BP, weight, height, and lung function
A:	[Assessment] A summary of the symptoms/diagnosis and differential diagnosis
P:	[Plan] The healthcare provider's plan that addresses the patient's concerns

Patient Name:_____ Today's Date: _____

Age: _____ Male/Female: _____ Medical Record #: _____

S:	**Subjective Data**
	How many days per week or how many times per day do you have asthma symptoms?
	How many nights per week or per month do you wake up because of asthma symptoms?
	How often do you use quick-relief medications for these symptoms?
	Do any of these symptoms interfere with your ☐ work? ☐ school? or ☐ exercise/activities? and how much? ☐ none ☐ 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

O:	**Objective Data**		
	Respiratory Assessment:	**Physical Examination:**	
		Vitals	**Physical Examination**
	Tobacco Use:	Temp:	HEENT:
	Today's Peak Flow:	HR:	Lungs:
	Labs:	RR:	Heart:
	X-rays:	BP:	Abdomen:
	Spirometry:	HT:	Extremities:
	ACT, ACQ, or ATAQ score:	WT:	Neuro:

Medications:

Controller Med:	Quick-Relief Med:
Concurrent Meds:	Other Treatments:

About what % of time are you taking your medicines? ☐ 100% ☐ 75% ☐ 50% ☐ less than 25%

Comorbidities: ☐ Allergic Rhinitis ☐ COPD ☐ Sinusitis ☐ GERD ☐ Eczema ☐ Obesity ☐ Diabetes
Other:

A:	**Assessment** (See next page to evaluate severity/classify control)

Classification of Severity Patient's initial assessment or patients not on controller medication(s)**:**
☐ 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

P:	**Plan** (See back cover for recommended action for treatment/stepwise approach)

☐ 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:

Provider Name/Signature: _____

Evaluating Asthma Severity (for patient NOT on controller medication[s])

Components of Severity		Classification of Asthma Severity (≥12 years of age)			
			Persistent		
		Intermittent	**Mild**	**Moderate**	**Severe**
Impairment Normal FEV_1/FVC: 8-19 yr 85% 20-39 yr 80% 40-59 yr 75% 60-80 yr 70%	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2x/month	3-4x/month	>1x/week but not nightly	Often 7x/week
	Short-acting beta$_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily, and not more than 1x on any day	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	• Normal FEV_1 between exacerbations • FEV_1 >80% predicted • FEV_1/FVC normal	• FEV_1 >80% predicted • FEV_1/FVC normal	• FEV_1 >60% but <80% predicted • FEV_1/FVC reduced 5%	• FEV_1 <60% predicted • FEV_1/FVC reduced >5%
Risk	Exacerbations requiring oral systemic corticosteroids	0-1 per year	≥2 per year ⟶		
		⟵ Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time for patients in any severity category. ⟶ Relative annual risk of exacerbations may be related to FEV_1.			
Recommended Step for Initiating Therapy		Step 1	Step 2	Step 3 and consider short course of oral systemic corticosteroids	Step 4 or 5
		In 2-6 weeks, evaluate level of asthma control that is achieved and adjust therapy accordingly.			

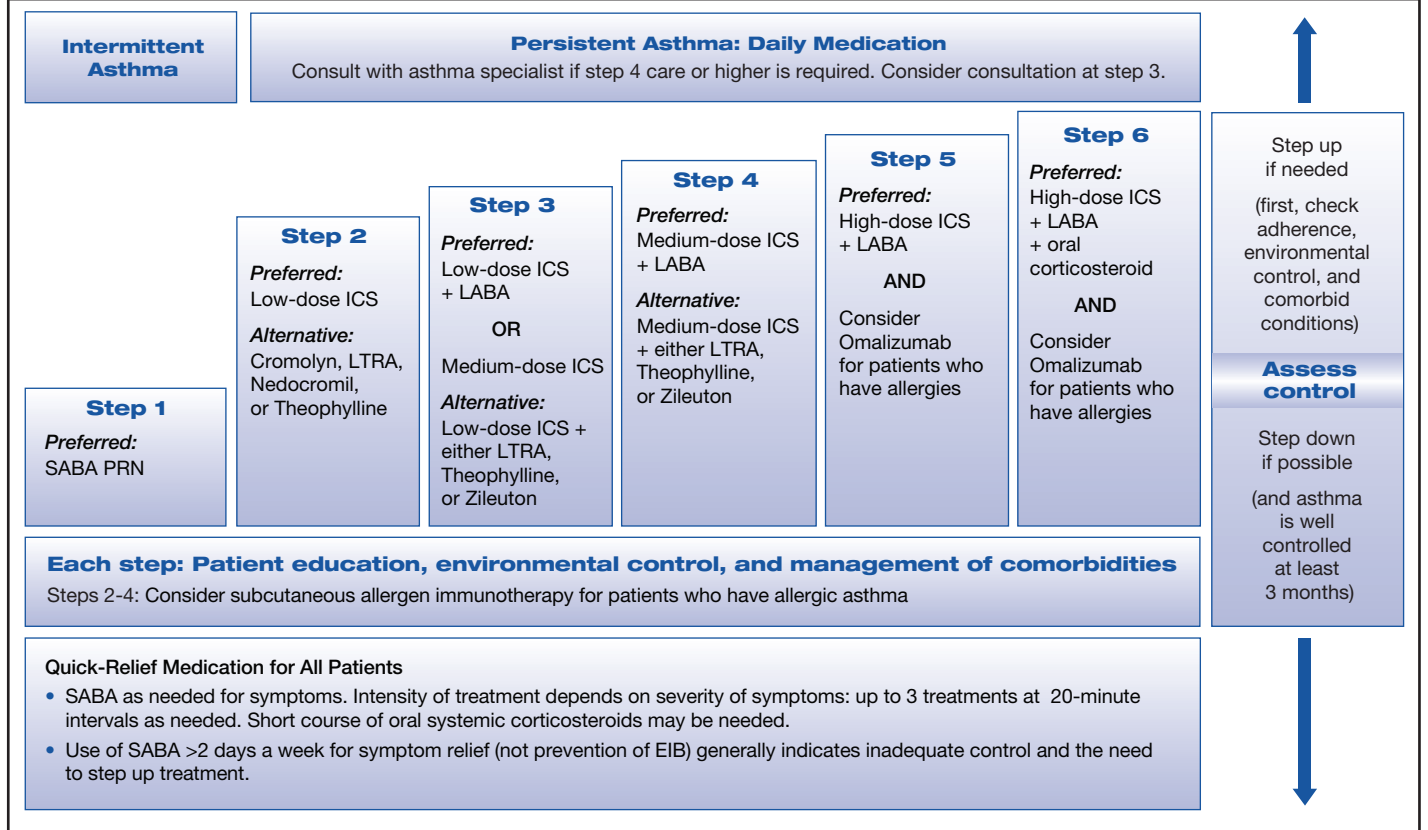## Classification of Asthma Control

Components of Control		Classification of Asthma Control (≥12 years of age)		
		Well Controlled	**Not Well Controlled**	**Very Poorly Controlled**
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakenings	≤2x/month	1-3x/week	≥4/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta$_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	FEV_1 or peak flow	>80% predicted/personal best	60-80% predicted/personal best	<60% predicted/personal best
	Validated questionnaires ATAQ ACQ ACT	 0 ≤0.75* ≥20	 1-2 ≥1.5 16-19	 3-4 N/A ≤15
Risk	Exacerbations requiring oral systemic corticosteroids	0-1 per year	≥2 per year	
		Consider severity and interval since last exacerbation		
	Progressive loss of lung function	Evaluation requires long-term followup care		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment		• Maintain current step. • Regular followup every 1-6 months to maintain control. • Consider step down if well controlled for at least 3 months.	• Step up 1 step and • Reevaluate in 2-6 weeks. • For side effects, consider alternative treatment options.	• Consider short course of oral systemic corticosteroids, • Step up 1-2 steps, and • Reevaluate in 2 weeks. • For side effects, consider alternative treatment options.

This information is directly abstracted from the 2007 NAEPP *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma*[1] and is not intended to promote or endorse any of the listed products.

*ACQ values of 0.76–1.4 are indeterminate regarding well-controlled asthma.

Key: EIB, exercise-induced bronchospasm; FEV_1, forced expiratory volume in 1 second

ACT, Asthma Control Test. Asthma Control Test is a trademark of QualityMetric Incorporated.

Stepwise Approach for Managing Asthma

Intermittent Asthma	Persistent Asthma: Daily Medication
	Consult with asthma specialist if step 4 care or higher is required. Consider consultation at step 3.

Step 1
Preferred:
SABA PRN

Step 2
Preferred:
Low-dose ICS

Alternative:
Cromolyn, LTRA, Nedocromil, or Theophylline

Step 3
Preferred:
Low-dose ICS + LABA

OR

Medium-dose ICS

Alternative:
Low-dose ICS + either LTRA, Theophylline, or Zileuton

Step 4
Preferred:
Medium-dose ICS + LABA

Alternative:
Medium-dose ICS + either LTRA, Theophylline, or Zileuton

Step 5
Preferred:
High-dose ICS + LABA

AND

Consider Omalizumab for patients who have allergies

Step 6
Preferred:
High-dose ICS + LABA + oral corticosteroid

AND

Consider Omalizumab for patients who have allergies

Step up if needed

(first, check adherence, environmental control, and comorbid conditions)

Assess control

Step down if possible

(and asthma is well controlled at least 3 months)

Each step: Patient education, environmental control, and management of comorbidities
Steps 2-4: Consider subcutaneous allergen immunotherapy for patients who have allergic asthma

Quick-Relief Medication for All Patients
- SABA as needed for symptoms. Intensity of treatment depends on severity of symptoms: up to 3 treatments at 20-minute intervals as needed. Short course of oral systemic corticosteroids may be needed.
- Use of SABA >2 days a week for symptom relief (not prevention of EIB) generally indicates inadequate control and the need to step up treatment.

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To access the complete *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma*, go to www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf.

Key: ICS, inhaled corticosteroid; LABA, inhaled long-acting beta$_2$-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta$_2$-agonist

Reference: 1. National Asthma Education and Prevention Program. *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma*. National Institutes of Health, National Heart, Lung, and Blood Institute. August 2007. NIH publication 08-4051.