Recurrent Respiratory Clinic

AH/AR/BA/CLD/CAR/INF/OTHERS,No:__________/yr Date:__ _/_ _/_ _ - _

AGE OF FIRST SYMPTOM:________________ AGE AT PROFORMA :__________ DOB:_______________

FULL NAME: ____

ADDRESS: ____ MOBILE: _ _ _ _ _ _ _ _ _ _

OTHER CONTACT : ____

WORKING DIAGNOSIS :____

MODIFIED DIAGNOSIS:____

SNEEZER/stuffy		COUGHER		WHEEZER		DISTRESS SCORE		NOISY BREATHING	
RUNNY NOSE		Cough-vomit?		EM>EN				STRIDOR	
SEASONAL		PERENNIAL		EPISODIC		EXERCISE InD		NOCTURNAL	
DAY		NIGHT		ADMISSIONS		ALLERGEN			
SHINERS		CREASE		A SALUTE		OTHER ALLERGY			
RDS		MAS		HYPOCa		LT MALACIA		GERD	
TB		HIV		CHD		VENTI			
FEVER FREQUENCY	/YR	NEBULISATIONS FREQUENCY	/YR	ADMISSIONS FREQUENCY	/YR	SYMPTOM GRADE		BREATH COUNT	

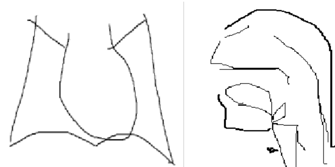
HC: TL/HT: WEIGHT: SAM: SOCIOECONOMY:
FAMILY HISTORY:
SCHOOL SPORTS STUDY SLEEP AFFECTED? PLZ CIRCLE RELEVANT

OTHER CLINICAL SIGNS/SYMPTOMS: PND/OTITIS,Eye,Ear,FEVERS ETC

SPECIFIC EXAMINATION FINDINGS: RR: Murmur: Throat: Wheeze: stridor:
Other: ____

MILD INTERMITTENT; MILD PERSISTANT, MODER. PERSISTANT, SEVER. PERSISTANT, ACUTE SEVERE A. COUGH VARIANT A., BRONCHIOLITIS/WARI/EARLY WHEEZER/TRANSIENT WHEEZER/PERSISTENT WHEEZER , recurrent viral fever, Rec Pneumonia SINUSITIS/BRONCHITIS/ADENOIDITIS/TONSILITIS/FB/ NASAL POLYPS/WA-CARDIAC/WA-GER, IMUNODEFICIENCY/ILD/CLD OTHERS clinical AH/radiological AH, Scopy finding: UNTREATED/TREATED/CONTROLLED/UMCONTROLLED

Hb/tc		AEC		IgE		ESR		CRP	
MT		KOCHS W/U							
XRC			XR NP/PNS						
CT *			ECHO*						
BEST PEFR	Fev1/fvc		RAST/SKIN TEST /OTHER						



PLAN: oral/inhalational, IEC, STEROID info, COMPLIANCE CHECK, DEFAULT CHECK, HOME MONITORING,HOME THERAPY

SYMPTOM GRADE	DAY SYMPTOMS PER WK	NIGHT SYMPTOMS PER MONTH	ACTIVITY RESTRICTION	PEFR LIMITATION
1 Kabhi kabhi	Ek ya do bar	Ek ya do bar		
2 Baar baar	Do se jyaada	Do se jyaada		
3 Prati din	Har roj (sticky days)	Har roj (sticky days)		
4 Prati raat	Har raat (sticky nights)	Har raat (sticky nights)		

VISIT EMERGENCY DEPATMENT FOR ANY ISSUES BEYOND RRC OPD HOURS, VISIT AS ADVICED/ EVERY 3 MONTHS www.breathingdiary.com

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Dr Kondekar s Asthma Assessment Questionnaire for Parents

	questions	yes	No/comment
1	Do you have Family history of diagnosed asthma/allergy?		
2	Do you have family history of smoking recent or current?		
3	Do you have family history of TB in recent or current or past?		
4	Does the child get at least an episode a monthly ?		
5	Are most of the episodes with significant fever?		
6	Does each episode begin with runny nose?		
7	Does each episode begin with sneezing?		
8	Does the child have sneeze dominant nose symptoms?		
9	Does the child rub nose often , scratch eyes, ears?		
10	Does the child make funny throat sounds?		
11	Did runny nose last for more than 10 days on any occasion?		
12	Does the child keep mouth open in sleep?		
13	Does the child snore in sleep?		
14	Does the child get frequent night awakenings due to nose or throat issues?		
15	Does the child cough more than wheeze?``		
16	Does the child wheeze more than cough?		
17	Is the cough more on lying down?		
18	Is the cough more late night or early morning?		
19	Does the child vomit after cough?		
20	Does the child get breathless every month for more than 6 hours?		
21	Does the child get breathless more at late night or early morning?		
22	Does the child have cough more than wheeze or breathlessness?		
23	Does the child get more than two sleepy nights a week?		
24	Does the child have reduced appetite?		
25	Does the child have slow swallowing?		
26	Does the child have constipationor straining or skipping a day motion?		
26	Do you think that dietary items aggrevate his symptoms?		
27	Do you think thatdust/smole/cold/diet/fumes smell etc things aggrevate symptoms?		
28	Does the child get similar symptoms on change of location?		
29	Is your child gaining appropriate weight?		
30	Did your child need repeated xrays/hospitalisations?		
31	Do the symptoms interfere in speech or sports or study?		
32	Do you offer milk to your child on daily basis?		
	OTA 3,5,6,11,12,13,1517,22,24,25,26,28,30 AND IF ITS NOT OTA ITS MOST LIKELY TO BE ASTHMA.		

1. OTA: STRONG SUSPECT
   major criteria: most likely OTA if:
   if most episodes come with fever
2. there is early night sleeping time discomfort but no early morning discomfort
3. there is obvious evidence of tonsilitis, adenoiditis, sinusitis, mouth breathing/nose block,foreign body inhalation, REFLUX
4. there is obvious evidence of other chronic disease like heart disease, renal disease, low calcium, microcephaly or failure to thrive or significant neonatal insult or delayed milestones
5. CT evidence of persistant patch 3 months apart, or CT evidence of specific disease
6. OTA- OTHER THAN ASTHMA
   SUSPECT : minor criteria: may be OTA if:

a. age of onset less than 4 years
b. first episode
c. no family history of asthma
d. no known allergy or sensitivity
e. repeatedly requires antibiotics
f. doesnt respond to asthma line therapy or symptoms despite steroid use
g. symptoms lasting months despite therapy
h. IgE not raised, no eosinophilia
i. spirometry reoeatedly normal
j. xray no hyper inflation, triangular chest shape

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BREATHING DIARY: 5 SECOND DAILY SYMPTOM RECALL DIARY

Patient diary format for home monitoring: √ IF PRESENT, * IF SEVERE SYMPTOMS, 0 IF NO SYMPTOMS , night 10pm to 10 am										Rescue puffs
DATE	NOSE SYMPTOMS		COUGH		WHEEZE/NOISE		BREATHLESS		PEFR	
	DAY Early night	NIGHT Early morning	DAY Early night	NIGHT Early morning	DAY Early night	NIGHT Early morning	DAY Early night	NIGHT Early morning		

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It s difficult to plan the therapy without proper symptom frequency in last 2 weeks prior to visit plz insist diary each visit.

FOLLOW UP NOTES AND THERAPY				
DATE	NEW SYMPTOMS	CONTROL OVER LAST 2 WEEKS	STEP UP/DOWN	OTHER THERAPY/INV REQUIRED
PEFR			R: M:	
PEFR				
PEFR				
PLAN THERAPY FOR 4 WEEKS. FOLLOW UP WITH SYMPTOM DIARY FOR FIRST FEW WEEKS. RAPID STEP UP AND SLOW STEP DOWN. TEACH THE PARENTS. ONCE STEPPED UP, DON T CHANGE FOR 4/6 WEEKS. AT LEAST 3 MONTHLY F/U IF SYMPTOM FREE. IF SYMPTOMATIC INSIST FREQUENT F/U. DETAILED EVALUATIONS IF TREATMENT FAILS. CALL DR SK FOR ANY QUERIES 9869405747				
PEFR				
PEFR				
PEFR				