Asthma Nursing Care Plan

Name: _____ Age: _____

Gender: _____ Date of admission: _____ dd / mm / yyyy

Allergies

Primary care physician: _____

History of asthma (include details such as age of onset, previous hospitalizations, or emergency visits for asthma)

Known triggers (e.g., allergens, exercise, tobacco smoke, etc.)

Other respiratory conditions (e.g., viral respiratory infections, chronic inflammation, etc.)

Current medications (include dosages and frequency)

Chief complaints

Description of symptoms (e.g., shortness of breath, wheezing, coughing, etc.)

Precipitating factors (any recent events that might have triggered symptoms)

Temperature: _____ Heart rate: _____

Respiratory rate: _____ Blood pressure: _____

Respiratory assessment (include respiratory status, breath sounds, peak flow readings, etc.)

Oxygen saturation (%): _____

Signs of respiratory distress

Nursing diagnosis

Short-term goals

Long term goals

Nursing interventions/implementation

Rationale

Evaluation

Name: _____ License ID: _____

Signature

Date: _____ dd / mm / yyyy