

Asthma Nursing Care Plan

Patient information	
Name:	Age:
Gender:	Date of admission:
Allergies:	Primary care physician:
Medical history	
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):
Assessment	
Subjective data (what the patient reports):	
Chief complaints:	

Description of symptoms (e.g., shortness of breath, wheezing, coughing, etc.):	Precipitating factors (any recent events that might have triggered symptoms):
Objective data (What the nurse observes):	
Vital signs:	Oxygen saturation (%):
Temperature:	Signs of respiratory distress:
Heart rate:	
Respiratory rate:	
Blood pressure:	
Respiratory assessment (include respiratory status, breath sounds, peak flow readings, etc.):	
Nursing diagnosis	
Goals/outcomes	
Short-term goals:	Long term goals:

Nursing interventions/implementation		Rationale	
Evaluation			
Nurse information			
Name:		License ID:	
Signature:		Date:	