



Asthma Health Tracker



Completing the Asthma Health Tracker: A companion to help you answer the questions

The *Asthma Health Tracker* gives you an opportunity to record and monitor information to help you more effectively manage your asthma. This document reviews each question on the *Asthma Health Tracker* and why it is important.

Vital Signs

Q: Height, weight and blood pressure

A: Your height, weight and blood pressure are basic measurements that are probably taken at each doctor's appointment. This information is important for managing your overall health. Your height and weight can be used to determine your body mass index (BMI). BMI helps you and your doctor determine if you are underweight, at a normal weight, overweight or obese. Your blood pressure gives an indication of how hard your heart is working. The blood pressure goal for most adults is 120/80 mm Hg.

Lab Tests

Q: HDL, LDL and total cholesterol and triglycerides

A: A lab test called a "lipid profile" or "lipid panel" provides information about the amount of cholesterol and other fats (lipids) in your blood. Too much cholesterol can lead to heart disease, a heart attack or a stroke. The lipid goals for most people are listed below. Talk with your doctor about the goal that is best for you and steps you can take to achieve it.

Lipid Goals for Most Adults (from ATP III Guidelines)		
Test	Value	Frequency
Total cholesterol	200 mg/dL or less	Yearly
HDL cholesterol	40 mg/dL or higher	Yearly
LDL cholesterol	100 mg/dL or less	Yearly
Triglycerides	150 mg/dL or less	Yearly

Examination

Q: Do you have a plan from your doctor to help you manage your asthma?

A: An Asthma Management Plan is an essential tool to help you manage your asthma. Asthma Management Plans are usually divided into three levels (zones) of asthma control:

- > **Green:** Your asthma is under control
- > **Yellow:** Warning—Take steps to get your asthma under control
- > **Red:** You need immediate help for your asthma

Talk with your doctor about creating a Plan. Your doctor will help you determine your personal criteria for each zone. Your doctor will also help you outline the exact steps you should take when you are in that zone.

Q: Do you get at least 30 minutes of moderate-intensity physical activity 4 or more days per week?

A: Regular physical activity has many health benefits for people with asthma. Exercise can help you control asthma and reduce your risk for other health problems. Most people should engage in at least 30 minutes of *moderate intensity* exercise (like brisk walking) on most days of the week. Talk with your doctor about exercising with asthma. Your healthcare team can help you develop an exercise program to meet your interests, abilities and needs.

Q: Do you have asthma symptoms such as coughing, wheezing or chest tightness during or after exercise?

A: Many people who experience asthma symptoms during exercise find they are able to exercise with minor changes in their treatment plan. Talk with your doctor about steps you can take to better control your asthma. Your doctor can also help you identify good activities for you. Don't let asthma stop you from enjoying life!

Q: In the past 4 weeks, have you awakened at night because of asthma symptoms?

A: Lung function varies between night and day for everyone. For people with asthma, this variation can lead to a worsening of symptoms. Other factors can also cause symptoms of asthma to be worse at night. It is important to tell your doctor about all symptoms you experience and when you experience them. Your doctor can evaluate possible causes of your worsening symptoms and adjust your treatment plan as needed.

Q: Do you currently smoke cigarettes, cigars or pipe tobacco?

A: Talk with your doctor about ways to quit. Your healthcare team can offer you support to stop smoking.

Examination (cont.)

Q: When did you have your last flu shot?

A: Vaccination is an important tool for preventing influenza (flu). Flu is a serious respiratory infection that can cause serious health problems in people with asthma. The Centers for Disease Control and Prevention (CDC) recommends that people with asthma age 6 months and older receive a flu shot in the fall of each year. A new vaccine is developed for each flu season, so a shot is necessary each year. There are some people for whom a flu shot is not recommended. Talk with your doctor about being vaccinated against the flu.

Q: Have you been vaccinated against pneumonia?

A: The pneumonia vaccine protects against pneumonia caused by certain bacteria. People with asthma who also have chronic bronchitis or emphysema or who use steroid medications long-term have an increased risk for pneumonia. This risk can be reduced through vaccination. Ask your doctor if you need to be vaccinated against pneumonia.

Medications

Q: Do you have a quick-relief or rescue inhaler?

A: Quick-relief or rescue inhalers are medications that are taken at the first sign of asthma symptoms. These medications work within minutes to relax your airways and let more air through. Use your rescue medication as directed. Tell your doctor if you use more than one inhaler per month. This may indicate that you need to adjust your asthma management plan. Check the expiration date of your rescue inhaler often, and replace it before it expires.

Q: Do you take a long-term control medication?

A: Long-term control medications are also used to prevent symptoms and asthma attacks. The full effect of these medications is usually not noticed until they have been taken for several weeks. It is important to use long-term control medications as directed. Proper use of your medications decreases your risk for severe asthma attacks and hospitalization. Talk with your healthcare team about anything that keeps you from using your asthma medication as directed.

Questions to Ask My Doctor: _____

Notes from Office Visit: _____

Participant's Bill of Rights and Responsibilities

Participants receiving services shall have the following rights:

1. To have information about the organization (including programs and services provided on behalf of the sponsoring organization), its personnel and its personnel's qualifications and any contractual relationships.
 2. To decline to participate or disenroll from the program and services at any time.
 3. To know which personnel are responsible for managing their individual care, if applicable, and from whom to request a change.
 4. To be informed of all condition management-related treatment options included or mentioned in clinical guidelines, whether covered or not by the sponsoring organization, and to discuss these with treating practitioners.
 5. To be assured of the confidential treatment of personal and clinical records and to know what entities have access to their information and what procedures are routinely utilized to protect confidential information. Please note that Matria may share your personal information, including personal health information as necessary, with your physician, health plan and those involved in your healthcare.
 6. To be informed prior to, or at the time of, initiating participation in the program, about the program's process for receiving, reviewing and resolving complaints, including standards for timeliness. To voice grievances and recommend changes in policies and services to the program's personnel, any appropriate agencies or other chosen representatives free from restraint, interference, coercion, discrimination, reprisal or unreasonable interruption of services.
 7. To be treated with respect, consideration and full recognition of dignity and individuality by all personnel involved with their care.
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8. To receive information that is understandable.
 9. To have the organization act as a participant advocate.
 10. To receive appropriate and quality services in a timely manner without discrimination because of age, race, religion, sex, handicap, national origin or sexual orientation.
 11. To be encouraged by the organization to make decisions interactively with his or her practitioner(s) regarding healthcare.

Participants receiving services shall have the following responsibilities:

1. To provide information necessary to carry out services, including providing accurate and complete health and insurance information concerning past illnesses, hospitalizations, medications, allergies and other pertinent items.
2. To participate in development, evaluation, and revision of a plan for their care and to adhere to this plan as agreed upon.
3. To inform the organization and treating practitioner if they decide to disenroll from the program.
4. To inform the organization of any change in treatment plan by a practitioner or admission to the hospital.
5. To inform the organization of any change in residence, phone number or practitioner.
6. To contact their physician if they have any concerns about their health or their treatment options, and in the event of an emergency, to call 911, as Matria's services are only educational in nature.
7. To contact their health plan if they are having any difficulty finding a qualified physician, as Matria does not make determinations about whether a physician is qualified or within your health plan's network

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Health Tracker | Asthma

This health tracker is designed to help you prepare for your next doctor's appointment and to monitor your progress in managing your asthma. At each doctor's visit, review each section with your doctor or nurse and fill it in, as applicable.

Please have your doctor sign where indicated, and return a copy to the address or toll-free fax number on page 2 after your visit.

Name: _____

Phone: _____

Date of Birth: _____

Date of visit	Date:	Date:	Date:	Date:
VITAL SIGNS				
Height	_____ ft _____ in	_____ ft _____ in	_____ ft _____ in	_____ ft _____ in
Weight	_____ lbs	_____ lbs	_____ lbs	_____ lbs
Blood pressure	_____/____ mm Hg	_____/____ mm Hg	_____/____ mm Hg	_____/____ mm Hg
LAB TESTS				
Cholesterol: Please list your last HDL, LDL and total cholesterol levels and triglyceride levels.	_____ HDL	_____ HDL	_____ HDL	_____ HDL
	_____ LDL	_____ LDL	_____ LDL	_____ LDL
	_____ Total	_____ Total	_____ Total	_____ Total
	_____ Trigly.	_____ Trigly.	_____ Trigly.	_____ Trigly.
EXAMINATION				
Do you have a plan from your doctor to help you manage your asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you get at least 30 minutes of moderate-intensity physical activity 4 or more days per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have asthma symptoms such as coughing, wheezing or chest tightness during or after exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past 4 weeks, have you awakened at night because of asthma symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



Asthma Health Tracker



The information contained herein is educational only, and is not intended to constitute medical advice or treatment. Your physician is your medical provider and you should contact him/her about any medical questions or changes to your plan of care.

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Take this booklet with you to doctor appointments. Please complete **both sides** of this form and return as soon as possible.

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EXAMINATION (cont.)

Do you currently smoke cigarettes, cigars or pipe tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
When did you have your last flu shot?	Date:	Date:	Date:	Date:
Have you been vaccinated against pneumonia?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:

MEDICATIONS

Do you have a quick-relief or rescue inhaler?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you taking inhaled corticosteroids or another long-term control medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Doctor's Notes: _____

Doctor's Signature: _____ Date: _____

Have your physician review the accuracy of the above and sign. **Mail this form to:** Health Benefits, P.O. Box 9429, Marietta, GA 30065
Or fax to: (800) 319-3624. **Please keep a copy for your personal records.** We will mail you a new Health Tracker for future use.