



# Asthma

*Daily Diary*



## *Asthma Daily Diary*

Asthma is a chronic lung disease that inflames and narrows the airways. This can cause symptoms like wheezing, coughing, tightness of the chest, and trouble breathing. You can live a healthy and active life as long as you keep it under control. You can control your asthma by knowing the warning signs of an attack, staying away from irritants, and following the advice of your health care provider.

Sometimes we have the best intentions to make lifestyle changes but time restrictions, family members or health issues can push us off track. Keeping a journal is a good way to help you reflect on your priorities, record your progress and identify areas to improve on. Each day, take a moment and choose a time that is convenient for you.

# How to use this asthma daily diary

This journal is your tool to help you control your asthma effectively. In your diary track flare-ups, medication side effects, triggers, or write down questions for your next doctor's appointment. In addition, record your:

1. **Symptoms:** Indicate if you experienced asthma symptoms and how severe they were.
2. **Peak flow readings:** Measure and record your peak flow in the morning and evening.
3. **Medications used:** Indicate the type of medication used each day and how many times you needed to use your rescue medications.

## Your Treatment Goals

1. Be free from severe symptoms day and night, including sleeping through the night.
2. Have the best possible lung function.
3. Be able to participate fully in any activity you choose.
4. Not miss work or school due to asthma symptoms.
5. No emergency visits or hospitalizations due to asthma.
6. Use asthma medications to control asthma, with few side effects.
7. Other: \_\_\_\_\_

## Your Asthma Medications

| Medication Name | Dosage | How often | Type (preventive/rescue) |
|-----------------|--------|-----------|--------------------------|
|                 |        |           |                          |
|                 |        |           |                          |
|                 |        |           |                          |
|                 |        |           |                          |
|                 |        |           |                          |
|                 |        |           |                          |

The following two pages contain examples of how to use this diary.

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough   |   | Wheeze  |   | Fatigue   |  | Breathing Problems   |   |   |
|-----------|---|---|---|---|---|--|--|---|---|
|           | Day   | Night   | Day   | Night   | Day   | Night  | Day  | Night   |   |
| Monday    | <input type="checkbox"/> Low<br><input checked="" type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input checked="" type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input checked="" type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input checked="" type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input checked="" type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input checked="" type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input checked="" type="checkbox"/> Severe |
| Tuesday   | <input checked="" type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input checked="" type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input checked="" type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input checked="" type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe            | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input checked="" type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input checked="" type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | ↑Symptomatic day example  |   |   |   |   |  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe            |   |
| Thursday  | Non symptomatic day example ↓   |   |   |   |   |  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe            |   |
| Friday    | <input checked="" type="checkbox"/> Low<br><input type="checkbox"/> Medium                                    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium   | <input checked="" type="checkbox"/> Low<br><input type="checkbox"/> Medium                                    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium                                    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium                                    | <input checked="" type="checkbox"/> Low<br><input type="checkbox"/> Medium                                    |   |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM  | Mid-Day | PM  | Late | Other |
|-----------|-----|---------|-----|------|-------|
| Monday    | 100 | 110     | 150 | —    | —     |
| Tuesday   | 175 | 175     | 180 | —    | —     |
| Wednesday |     |         |     |      |       |
| Thursday  |     |         |     |      |       |
| Friday    | 250 | —       | 275 | —    | —     |

PRESCRIPTION

Rx

Please follow your doctor's recommendations for checking your peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other           |
|-----------|---|---|---|-----------------|
| Monday    | <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM            | <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/><br><i>6 doses</i> | <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM            | —               |
| Tuesday   | <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM            | <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br><i>5 doses</i>                       | <input checked="" type="checkbox"/> AM <input checked="" type="checkbox"/> PM | <i>Steroids</i> |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM                       | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   | <input type="checkbox"/> AM <input type="checkbox"/> PM                       | <i>Steroids</i> |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM                       | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   | <input type="checkbox"/> AM <input type="checkbox"/> PM                       | <i>Steroids</i> |
| Friday    | <input checked="" type="checkbox"/> AM <input checked="" type="checkbox"/> PM | <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br><i>1 dose</i>   | <input type="checkbox"/> AM <input type="checkbox"/> PM                       | <i>Steroids</i> |

# Diary

Week March 20, 2023

**Monday** *Developed cold, saw doctor that afternoon, prescribed antibiotics and steroids.*

**Tuesday** *Started steroids that morning.*

Week of:

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough  |  | Wheeze   |  | Fatigue  |  | Breathing Problems   |  |
|-----------|--|--|--|--|--|--|--|--|
|           | Day  | Night  | Day  | Night  | Day  | Night  | Day  | Night  |
| Monday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Tuesday   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Thursday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Friday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Saturday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Sunday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM | Mid-Day | PM | Late | Other |
|-----------|----|---------|----|------|-------|
| Monday    |    |         |    |      |       |
| Tuesday   |    |         |    |      |       |
| Wednesday |    |         |    |      |       |
| Thursday  |    |         |    |      |       |
| Friday    |    |         |    |      |       |
| Saturday  |    |         |    |      |       |
| Sunday    |    |         |    |      |       |

PRESCRIPTION

Please follow your doctor's recommendations for checking your peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other |
|-----------|---|---|---|-------|
| Monday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Tuesday   | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Friday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Saturday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Sunday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |

# Diary

Week \_\_\_\_\_

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

*Know your early warning  
signs of a flare-up.*



Week of:

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough  |  | Wheeze   |  | Fatigue  |  | Breathing Problems   |  |
|-----------|--|--|--|--|--|--|--|--|
|           | Day  | Night  | Day  | Night  | Day  | Night  | Day  | Night  |
| Monday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Tuesday   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Thursday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Friday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Saturday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Sunday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM | Mid-Day | PM | Late | Other |
|-----------|----|---------|----|------|-------|
| Monday    |    |         |    |      |       |
| Tuesday   |    |         |    |      |       |
| Wednesday |    |         |    |      |       |
| Thursday  |    |         |    |      |       |
| Friday    |    |         |    |      |       |
| Saturday  |    |         |    |      |       |
| Sunday    |    |         |    |      |       |

PRESCRIPTION

Rx

Please follow  
your doctor's  
recommendations  
for checking your  
peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other |
|-----------|---|---|---|-------|
| Monday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Tuesday   | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Friday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Saturday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Sunday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |



# Diary

Week \_\_\_\_\_

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

*Keep your quick-relief medication  
with you at all times.*



Week of:

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough  |  | Wheeze   |  | Fatigue  |  | Breathing Problems   |  |  |
|-----------|--|--|--|--|--|--|--|--|--|
|           | Day  | Night  | Day  | Night  | Day  | Night  | Day  | Night  |  |
| Monday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Tuesday   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Thursday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Friday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Saturday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Sunday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM | Mid-Day | PM | Late | Other |
|-----------|----|---------|----|------|-------|
| Monday    |    |         |    |      |       |
| Tuesday   |    |         |    |      |       |
| Wednesday |    |         |    |      |       |
| Thursday  |    |         |    |      |       |
| Friday    |    |         |    |      |       |
| Saturday  |    |         |    |      |       |
| Sunday    |    |         |    |      |       |

PRESCRIPTION

Rx

Please follow  
your doctor's  
recommendations  
for checking your  
peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other |
|-----------|---|---|---|-------|
| Monday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Tuesday   | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Friday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Saturday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Sunday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |

# Diary

Week \_\_\_\_\_

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

*Review your action plan with  
your doctor regularly.*



Week of:

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough  |  | Wheeze   |  | Fatigue  |  | Breathing Problems   |  |
|-----------|--|--|--|--|--|--|--|--|
|           | Day  | Night  | Day  | Night  | Day  | Night  | Day  | Night  |
| Monday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Tuesday   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Thursday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Friday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Saturday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Sunday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM | Mid-Day | PM | Late | Other |
|-----------|----|---------|----|------|-------|
| Monday    |    |         |    |      |       |
| Tuesday   |    |         |    |      |       |
| Wednesday |    |         |    |      |       |
| Thursday  |    |         |    |      |       |
| Friday    |    |         |    |      |       |
| Saturday  |    |         |    |      |       |
| Sunday    |    |         |    |      |       |

PRESCRIPTION

Rx

Please follow  
your doctor's  
recommendations  
for checking your  
peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other |
|-----------|---|---|---|-------|
| Monday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Tuesday   | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Friday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Saturday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Sunday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |

# Diary

Week \_\_\_\_\_

Monday

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Tuesday

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Wednesday

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Thursday

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Friday

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Saturday

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Sunday

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*Measure and record your peak flow meter reading and symptoms every day.*





Week of:

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough  |  | Wheeze   |  | Fatigue  |  | Breathing Problems   |  |
|-----------|--|--|--|--|--|--|--|--|
|           | Day  | Night  | Day  | Night  | Day  | Night  | Day  | Night  |
| Monday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Tuesday   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Thursday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Friday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Saturday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Sunday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM | Mid-Day | PM | Late | Other |
|-----------|----|---------|----|------|-------|
| Monday    |    |         |    |      |       |
| Tuesday   |    |         |    |      |       |
| Wednesday |    |         |    |      |       |
| Thursday  |    |         |    |      |       |
| Friday    |    |         |    |      |       |
| Saturday  |    |         |    |      |       |
| Sunday    |    |         |    |      |       |

PRESCRIPTION

Rx

Please follow  
your doctor's  
recommendations  
for checking your  
peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other |
|-----------|---|---|---|-------|
| Monday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Tuesday   | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Friday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Saturday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Sunday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |

# Diary

Week \_\_\_\_\_

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

*List situations that cause you stress and tension,  
and explain how it affects your breathing.*



Week of:

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough  |  | Wheeze   |  | Fatigue  |  | Breathing Problems   |  |
|-----------|--|--|--|--|--|--|--|--|
|           | Day  | Night  | Day  | Night  | Day  | Night  | Day  | Night  |
| Monday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Tuesday   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Thursday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Friday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Saturday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Sunday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM | Mid-Day | PM | Late | Other |
|-----------|----|---------|----|------|-------|
| Monday    |    |         |    |      |       |
| Tuesday   |    |         |    |      |       |
| Wednesday |    |         |    |      |       |
| Thursday  |    |         |    |      |       |
| Friday    |    |         |    |      |       |
| Saturday  |    |         |    |      |       |
| Sunday    |    |         |    |      |       |

PRESCRIPTION

Rx

Please follow  
your doctor's  
recommendations  
for checking your  
peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other |
|-----------|---|---|---|-------|
| Monday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Tuesday   | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Friday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Saturday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Sunday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |

# Diary

Week \_\_\_\_\_

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

*Be tobacco-free to improve your health  
and reduce asthma symptoms.*



Week of:

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough  |  | Wheeze   |  | Fatigue  |  | Breathing Problems   |  |  |
|-----------|--|--|--|--|--|--|--|--|--|
|           | Day  | Night  | Day  | Night  | Day  | Night  | Day  | Night  |  |
| Monday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Tuesday   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Thursday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Friday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Saturday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Sunday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM | Mid-Day | PM | Late | Other |
|-----------|----|---------|----|------|-------|
| Monday    |    |         |    |      |       |
| Tuesday   |    |         |    |      |       |
| Wednesday |    |         |    |      |       |
| Thursday  |    |         |    |      |       |
| Friday    |    |         |    |      |       |
| Saturday  |    |         |    |      |       |
| Sunday    |    |         |    |      |       |

PRESCRIPTION

Rx

Please follow your doctor's recommendations for checking your peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other |
|-----------|---|---|---|-------|
| Monday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Tuesday   | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Friday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Saturday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Sunday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |

# Diary

Week \_\_\_\_\_

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday



*Don't hang your clothes outside to dry as pollens and mold can collect in the fabric.*



Week of:

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough  |  | Wheeze   |  | Fatigue  |  | Breathing Problems   |  |
|-----------|--|--|--|--|--|--|--|--|
|           | Day  | Night  | Day  | Night  | Day  | Night  | Day  | Night  |
| Monday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Tuesday   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Thursday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Friday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Saturday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Sunday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM | Mid-Day | PM | Late | Other |
|-----------|----|---------|----|------|-------|
| Monday    |    |         |    |      |       |
| Tuesday   |    |         |    |      |       |
| Wednesday |    |         |    |      |       |
| Thursday  |    |         |    |      |       |
| Friday    |    |         |    |      |       |
| Saturday  |    |         |    |      |       |
| Sunday    |    |         |    |      |       |

PRESCRIPTION

Rx

Please follow your doctor's recommendations for checking your peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other |
|-----------|---|---|---|-------|
| Monday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Tuesday   | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Friday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Saturday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Sunday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |

# Diary

Week \_\_\_\_\_

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Monday

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Tuesday

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Wednesday

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Thursday

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Friday

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Saturday

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Sunday

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*Wash your hands after touching pets and  
avoid having them sleep in your bedroom.*



Week of:

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough  |  | Wheeze   |  | Fatigue  |  | Breathing Problems   |  |  |
|-----------|--|--|--|--|--|--|--|--|--|
|           | Day  | Night  | Day  | Night  | Day  | Night  | Day  | Night  |  |
| Monday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Tuesday   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Thursday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Friday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Saturday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Sunday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM | Mid-Day | PM | Late | Other |
|-----------|----|---------|----|------|-------|
| Monday    |    |         |    |      |       |
| Tuesday   |    |         |    |      |       |
| Wednesday |    |         |    |      |       |
| Thursday  |    |         |    |      |       |
| Friday    |    |         |    |      |       |
| Saturday  |    |         |    |      |       |
| Sunday    |    |         |    |      |       |

PRESCRIPTION

Rx

Please follow  
your doctor's  
recommendations  
for checking your  
peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other |
|-----------|---|---|---|-------|
| Monday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Tuesday   | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Friday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Saturday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Sunday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |

# Diary

Week \_\_\_\_\_

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

*Enclose mattresses, box springs and pillows in non-allergenic cases.*



Week of:

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough  |  | Wheeze   |  | Fatigue  |  | Breathing Problems   |  |
|-----------|--|--|--|--|--|--|--|--|
|           | Day  | Night  | Day  | Night  | Day  | Night  | Day  | Night  |
| Monday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Tuesday   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Thursday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Friday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Saturday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Sunday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM | Mid-Day | PM | Late | Other |
|-----------|----|---------|----|------|-------|
| Monday    |    |         |    |      |       |
| Tuesday   |    |         |    |      |       |
| Wednesday |    |         |    |      |       |
| Thursday  |    |         |    |      |       |
| Friday    |    |         |    |      |       |
| Saturday  |    |         |    |      |       |
| Sunday    |    |         |    |      |       |

PRESCRIPTION

Rx

Please follow  
your doctor's  
recommendations  
for checking your  
peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other |
|-----------|---|---|---|-------|
| Monday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Tuesday   | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Friday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Saturday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Sunday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |



# Diary

Week \_\_\_\_\_

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday



*Identify your  
asthma triggers  
and avoid them.*



Week of:

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough  |  | Wheeze   |  | Fatigue  |  | Breathing Problems   |  |
|-----------|--|--|--|--|--|--|--|--|
|           | Day  | Night  | Day  | Night  | Day  | Night  | Day  | Night  |
| Monday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Tuesday   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Thursday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Friday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Saturday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Sunday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM | Mid-Day | PM | Late | Other |
|-----------|----|---------|----|------|-------|
| Monday    |    |         |    |      |       |
| Tuesday   |    |         |    |      |       |
| Wednesday |    |         |    |      |       |
| Thursday  |    |         |    |      |       |
| Friday    |    |         |    |      |       |
| Saturday  |    |         |    |      |       |
| Sunday    |    |         |    |      |       |

PRESCRIPTION

Rx

Please follow your doctor's recommendations for checking your peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other |
|-----------|---|---|---|-------|
| Monday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Tuesday   | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Friday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Saturday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Sunday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |

# Diary

Week \_\_\_\_\_

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

*Don't let children keep stuffed animals on their beds.*



Week of:

## Asthma Symptoms

Check boxes below to indicate when you experienced symptoms and their severity.

|           | Cough  |  | Wheeze   |  | Fatigue  |  | Breathing Problems   |  |  |
|-----------|--|--|--|--|--|--|--|--|--|
|           | Day  | Night  | Day  | Night  | Day  | Night  | Day  | Night  |  |
| Monday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Tuesday   | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Wednesday | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Thursday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Friday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Saturday  | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |
| Sunday    | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe | <input type="checkbox"/> Low<br><input type="checkbox"/> Medium<br><input type="checkbox"/> Severe |

## Peak Flow Readings

Record your daily peak flow readings.

|           | AM | Mid-Day | PM | Late | Other |
|-----------|----|---------|----|------|-------|
| Monday    |    |         |    |      |       |
| Tuesday   |    |         |    |      |       |
| Wednesday |    |         |    |      |       |
| Thursday  |    |         |    |      |       |
| Friday    |    |         |    |      |       |
| Saturday  |    |         |    |      |       |
| Sunday    |    |         |    |      |       |

PRESCRIPTION

Rx

Please follow your doctor's recommendations for checking your peak flow readings.

## Medication Use

Check the medications you used each day and how often you used them.

|           | Maintenance   | Rescue  | Nebulizer   | Other |
|-----------|---|---|---|-------|
| Monday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Tuesday   | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Wednesday | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Thursday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Friday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Saturday  | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |
| Sunday    | <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> AM <input type="checkbox"/> PM |       |

# Diary

Week \_\_\_\_\_

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Monday

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Tuesday

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Wednesday

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Thursday

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Friday

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Saturday

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Sunday

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# *CONGRATULATIONS!*

You've completed your  
Asthma Daily Diary.

**Don't stop here.  
Continue your habits for a lifetime!**





# Notes

## Notes

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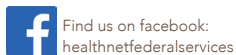
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