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Asthma Journal

Fill out your journal pages and bring them to your next healthcare provider visit.

Date _____

1. Did you experience any of the following asthma symptoms today? (Check all that apply.)

_____ WHEEZING _____ SHORTNESS OF BREATH _____ TIGHTNESS IN CHEST _____ COUGH

If yes, what do you think may have triggered your symptoms? _____

2. Did you miss or avoid any activities today due to asthma symptoms?

_____ YES _____ NO

3. How did you sleep last night? (Check one.)

_____ NO WAKING; NO WHEEZING OR COUGHING

_____ SLEPT WELL; SLIGHT WHEEZE OR COUGH

_____ AWAKE 2-3 TIMES; WHEEZE OR COUGH

_____ BAD NIGHT; AWAKE MOST OF THE TIME

4. Did you take your daily preventative medications (other than your quick-relief inhaler) **today?**

_____ YES _____ NO

If not, was it because you:

_____ WERE TOO BUSY _____ FELT FINE _____ WERE OUT OF MEDICATION _____ SIMPLY FORGOT _____ OTHER

5. Did you use your quick-relief inhaler today?

_____ YES _____ NO

If yes, how many puffs and how often? _____

6. Did you have an asthma attack today?

_____ YES _____ NO

7. My peak flow today was _____ **when I checked at** _____ **AM/PM.**

8. Other comments/observations:

_____

_____