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
   _____ WOKE UP 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 IN AM/PM (CIRCLE ONE)

8. Other comments/observations:
   ______________________________________
   ______________________________________
   ______________________________________
   ______________________________________
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