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:
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________