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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_____

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