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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Doctor Discussion Guide

Use the space provided to write down your answers. Bring your written answers to your next appointment and discuss them with your healthcare provider.

1. Which medications are you taking for asthma?

	HOW MUCH	WHEN
	HOW MUCH	WHEN
	HOW MUCH	WHEN
	HOW MUCH	WHEN

2. How often do you use your rescue inhaler?

3. List any other medications you are taking, including vitamins and herbal supplements.

4. What asthma symptoms are you experiencing (wheezing, coughing, chest tightness, shortness of breath)?

a. What things (triggers) make your asthma symptoms worse?

5. How often are you experiencing symptoms?

6. Do your asthma symptoms affect usual activities? If so, how?

7. Do you have an Asthma Action Plan? If so, what steps have you taken to work toward your goals?

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