

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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