

Asthma Weekly Diary

Name : _____

Week of : _____

Doctor : _____

Doctor's phone number: _____

	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
Symptoms	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night
Cough														
Wheeze														
Shortness of breath														
Chest tightness														
Peak Flow Readings	Record your daily peak flow meter readings.													
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night
Green _____														
Yellow _____														
Red _____														
Medicines	List your medicines and the number of times you took them each day.													
Daily Activity and Triggers	List the activities or exposure to things that may have triggered symptoms.													