Symptoms (please tick box)

		MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	
a. Did you cough today?	a.															a.
b. Did you wheeze today?	b.															b.
c. Were you short of breath today?	c.															c.
d. Did you asthma wake you at night?	d.															d.
e. Were you off school/work today?	e.															e.

NOTE: Peak flow measurements that are frequently one-third or more below your best may mean that your asthma is not properly controlled. Please check with your Doctor/Asthma clinic about your treatment

	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
700																													700
650																													650
600																													600
550																													550
500																													500
450																													450
400																													400
350																													350
300																													300
250																													250
200																													200
150																													150
100																													100
50																													50

TREATMENT: Ask your doctor to write down the treatments prescribed for you below

		DOSE / DAY														
1	(Reliever)			1												1
2	(Preventer)			2												2
3	(Protector)			3												3
4				4												4
5				5												5