Asthma Guidance

KEEPING AN ASTHMA DIARY

A PERSONAL ACTION PLAN

Here's a list of routine asthma symptoms such as coughing, wheezing, tightness in the chest, shortness of breath, and excess mucus production, as well as what you should do if these symptoms occur.

Take this diary with you to your doctor's appointment. This will help your doctor to assess any changes in your health.

Symptom use a check mark to show when you had symptoms	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night
Coughing														
Wheezing														
Chest tightness														
Breathing problems														
Excess mucus														

DEFINING THE ZONES

For convenience, asthma action plans are often broken down into three zones on your peak flow meter: green, yellow, and red. In each zone, your asthma action plan will give you doctor-written instructions on how to handle each circumstance.

GREEN ZONE

Where you should be every day – no asthma symptoms. You are able to do usual activities and sleep without coughing, wheezing, or breathing difficulties. Peak flow is 80% to 100% of personal best.

YELLOW ZONE

This is not where you should be. Your symptoms may include coughing, wheezing, and mild shortness of breath. You may have nighttime asthma and daily activities may be disturbed. You may be more tired than usual. Peak flow is 50% to 80% of personal best. Call your doctor if you keep dropping into the yellow zone. The green zone plan may need to be changed to prevent this.

RED ZONE

Red zone means you need urgent medical care. Your asthma symptoms may include frequent, severe cough, severe shortness of breath, wheezing, trouble talking, walking, and rapid breathing. Peak flow is less than 50% of personal best. If you are gasping for air, have blue lips or fingernails, or are unable to do a peak flow, call your Emergency support services.

You can record your peak flow results over the page.

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2. Peak flow readings

Write your peak flow readings in the corresponding colour zone.

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night

3. MEDICINE

List your medicines and the number of times you took them each day.

Medicine name	MON	TUE	WED	THU	FRI	SAT	SUN

YOUR DETAILS

Name: _____

Week/Month/Year: _____

Doctor's name: _____

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