



SYMPTOM DIARY

Example DAY

MY SYMPTOMS	Did your asthma wake you up last night?	<input checked="" type="checkbox"/>
	Did you cough today?	<input checked="" type="checkbox"/>
	Did you wheeze today?	<input type="checkbox"/>
	Did your asthma affect your normal activity?	<input checked="" type="checkbox"/>
	How are you feeling?	

MY TREATMENT		AM	
		PM	
		AM	
		PM	
		AM	
		PM	
		AM	
		PM	

Write in your medicines here and record how many times you took them each day.

Example DAY

MY SYMPTOMS	Did your asthma wake you up last night?	<input checked="" type="checkbox"/>
	Did you cough today?	<input checked="" type="checkbox"/>
	Did you wheeze today?	<input type="checkbox"/>
	Did your asthma affect your normal activity?	<input checked="" type="checkbox"/>
	How are you feeling?	

MY TREATMENT		AM	
		PM	
		AM	
		PM	
		AM	
		PM	
		AM	
		PM	

WEEK 1 DATE

MON	TUE	WED	THU	FRI	SAT	SUN

WEEK 4 DATE

MON	TUE	WED	THU	FRI	SAT	SUN

WEEK 2 DATE

MON	TUE	WED	THU	FRI	SAT	SUN

WEEK 5 DATE

MON	TUE	WED	THU	FRI	SAT	SUN

WEEK 3 DATE

MON	TUE	WED	THU	FRI	SAT	SUN

WEEK 6 DATE

MON	TUE	WED	THU	FRI	SAT	SUN

asthma.ie



ASTHMA ADVICELINE

1800 44 54 64

BEATING BREATHLESSNESS WHATSAPP

086 059 0132

