

ASTHMA MANAGEMENT PLAN

Date you started this Diary

8/119/1110/1112/11

1. Have you had any asthma symptoms during the day (coughing, wheeze, tight chest or feeling breathless).

2. Has your asthma interfered with your usual activities (e.g. housework, climbing stairs, work or school, exercise).

3. Have you had difficulty sleeping because of your asthma symptoms (including coughing)

4. Have you needed to use your reliever inhaler more than twice a week

5. Have you had nasal symptoms (eg nasal congestion, sneezing, post nasal drip etc.)

GREEN ZONE: ASTHMA UNDER CONTROL

Daytime symptoms less than twice/week

No limitation of exercise

No waking at night due to symptoms

Reliever medication used less than twice per week

Peak flow between _____ and _____

Peak Flow between 80-100% of Personal Best

Your Regular Treatment. Each day take:

1. Reliever _____

2. Controller _____

3. _____

4. _____

Before Exercise take _____

Write down the total number of times you took your treatment each day.

8/11

9/11

10/11

12/11

✓

✓

✓

✓

BLUE ZONE: ASTHMA GETTING WORSE

Daytime symptoms more than twice/week?

Getting chesty cough?

Waking at night with cough or wheeze?

New or increased daytime cough or wheeze?

Symptoms after activity or exercise?

Using reliever meds more than twice per week?

Peak flow between _____ and _____

Peak Flow between 60-80% of Personal Best

If you answered 'yes' to 3 or more of these questions, your asthma is uncontrolled and you may need to step up your treatment.

Step up your treatment as follows:

1. Increase your reliever to _____

2. Take _____

The need for repeated doses over more than 1 or 2 days signals the need for a review by your doctor.

Use a spacer device if possible for maximum benefit.

ORANGE ZONE: ASTHMA BECOMING SEVERE

Symptoms becoming more severe

Becoming breathless at rest

Chest tightness

Reliever medication has poor or short lived effect

Peak flow between _____ and _____

Peak Flow between 40-60% of Personal Best

Call your doctor/clinic: Phone No. _____ and get immediate advice.

Take the following medication.

1. Increase your reliever use to _____

2. Additional Instructions _____

3. Take _____ mg of _____ (oral steroid) if prescribed.

Out of hours contact _____

Use a spacer device if possible for maximum benefit.

RED ZONE: EMERGENCY

Shortness of breath

Can only speak in short sentences

Trouble walking

Lips are blue

Short lived response to reliever.

Peak flow is less than _____

Peak Flow is less than 40% of Personal Best

Get medical help immediately.

Go to _____ Phone: _____

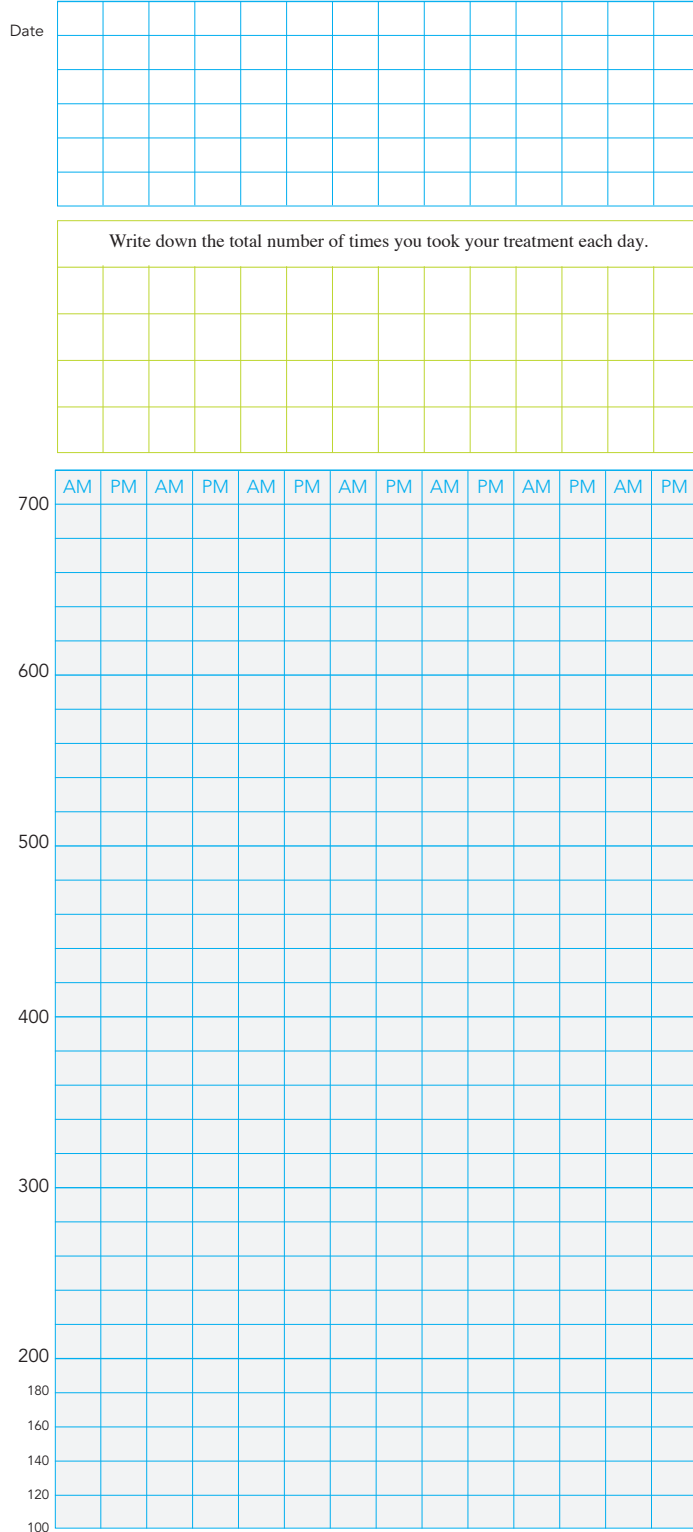
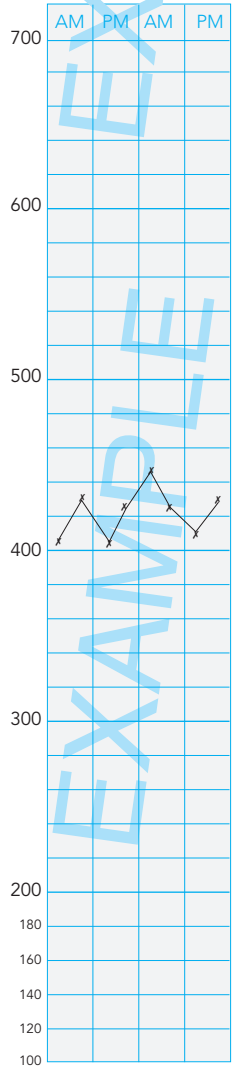
Out of Hours: _____

Take 2 to 4 puffs of your reliever inhaler

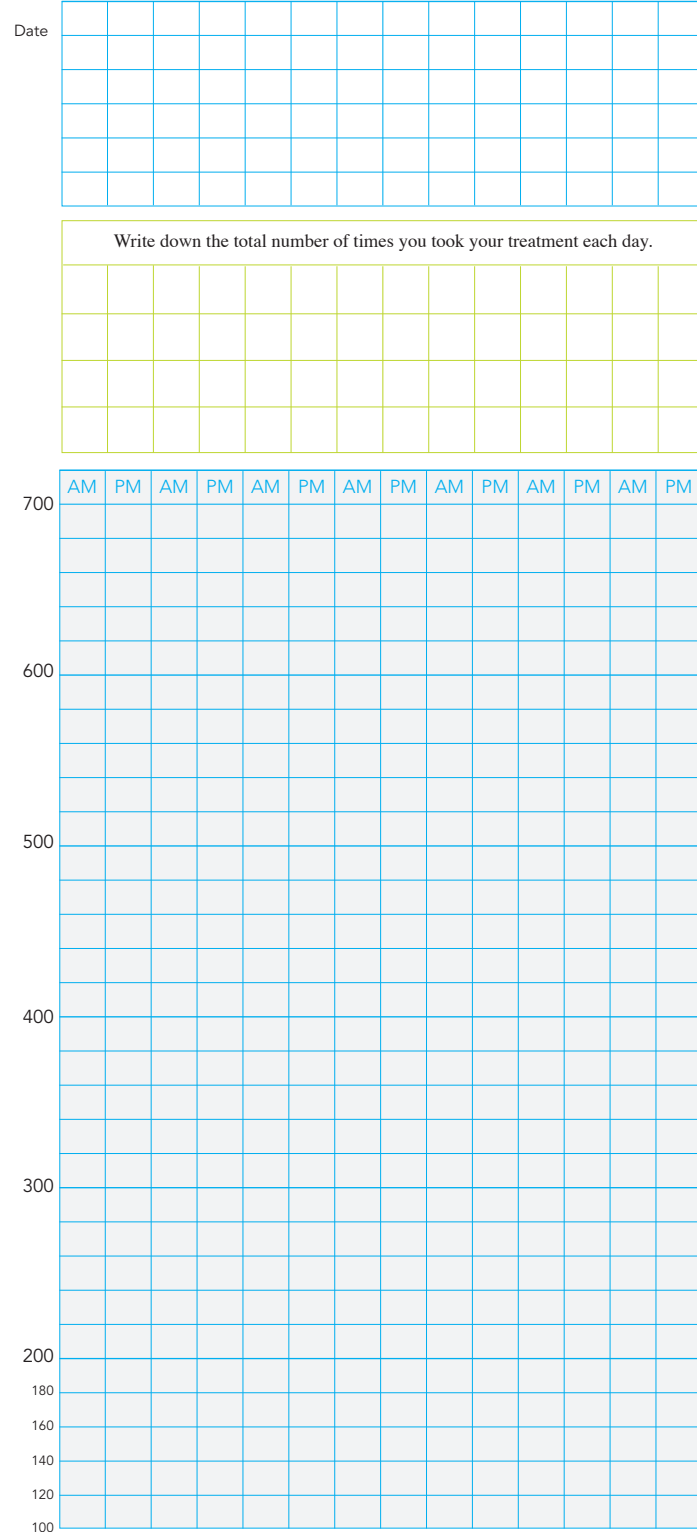
Take _____ mg of _____ (oral steroid) if prescribed.

Continue to take 2 puffs of reliever every minute until symptoms improve or help arrives.

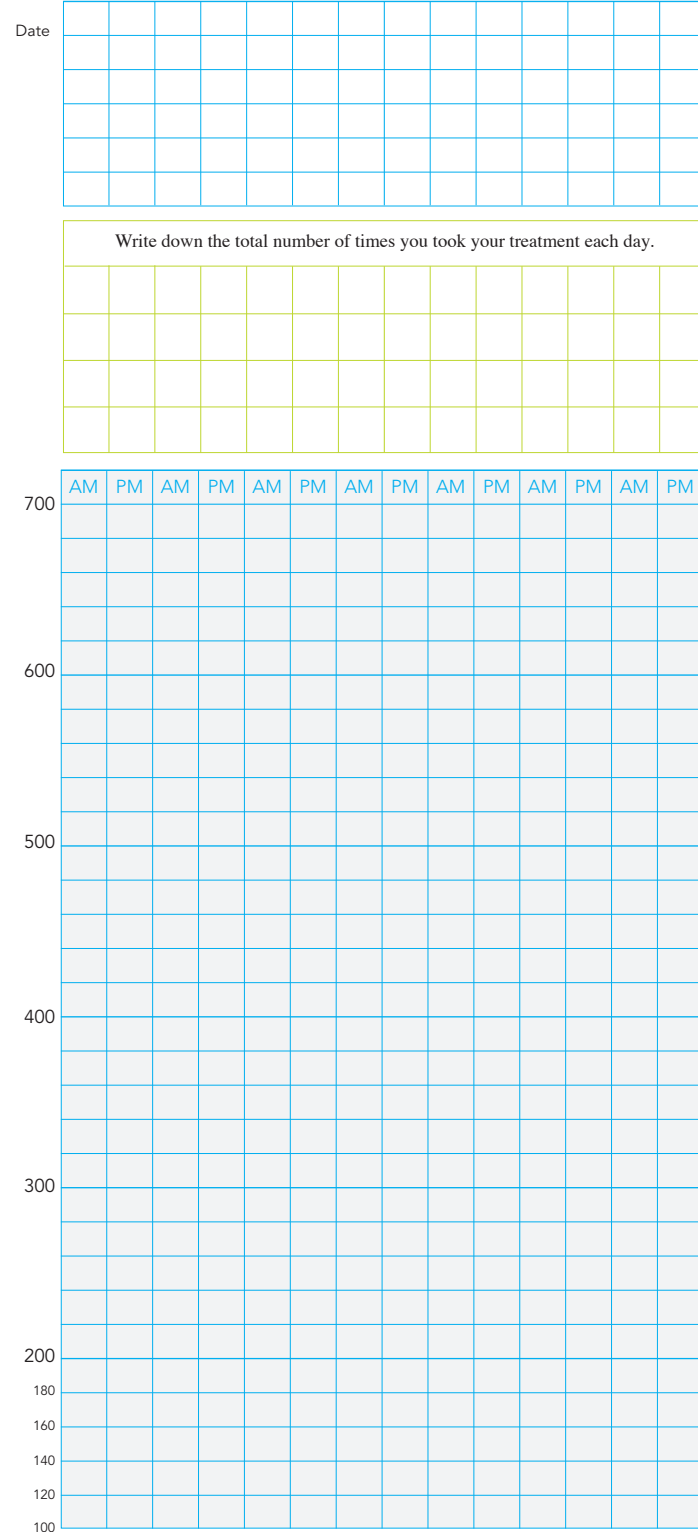
Use a spacer device if possible for maximum benefit.



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