Allergy & Asthma NETWORK

AsthmaTracker®

Name: _____ **Physician:** _____ **Phone:** _____

Month _____

Rate Your Symptoms: (0 = None to 5 = Severe)		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Cough																															
	Wheezing																															
	Shortness of Breath or Chest Tightness																															
	Nasal Symptoms (S = stuffy, R = runny, D = drainage)																															
	Sinus Symptoms																															
	Interrupted Sleep																															
	Exercise Related																															
	Reflux or Indigestion (GERD)																															
	Eyes (Itching, Redness, Swelling)																															
	Skin Irritation																															
	Anaphylaxis																															
PFM Reading	☐ Target Peak Flow Meter Reading Green: ____ to ____ Yellow: ____ to ____ Red: ____ and below	A.M.																														
		Noon																														
		P.M.																														
Y = "Yes" N = "No"	Missed work and/or school today?																															
	Required an unplanned medical visit today?																															
Which Medications Did You Take Today?	1.																															
	2.																															
	3.																															
	4.																															
	5.																															
	6.																															

To order additional AsthmaTrackers contact Allergy & Asthma Network at 800.878.4403 or visit *AllergyAsthmaNetwork.org*

AsthmaTracker®

Peak Expiratory Flow Rate (PEFR)

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Time	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	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	AM PM	AM PM	AM PM
_00																															
_50																															
_00																															
_50																															
_00																															

Medications

To be filled in by your physician or nurse educator.

Medication	Dose	When to take	How long does it last?	How medication works

PEFR

Green: _____ to _____ Yellow: _____ to _____ Red: _____ and below

Unscheduled Dr.'s or ER visits/why: _____

Questions, concerns and daily symptoms: _____

2015

800.878.4403 AllergyAsthmaNetwork.org