

Name: _____ Emergency Contact: _____ Phone: _____ Date: _____
 Doctor: _____ Phone: _____

Severity level: Intermittent Mild Moderate Severe

Triggers: Outdoor Air/Pollutants/Irritants Cockroach Pets Mold Emotions Exercise
 Cold & Flu Food/Additives Pollen Environmental/Tobacco smoke Dust Mites/ Dust

Symptoms		Treatment		
Well ➤ No cough ➤ No wheeze ➤ No chest tightness ➤ No shortness of breath	Green Zone Peak Flow _____ (> 80 % of best peak flow) Best Peak Flow _____	Medication	How Much	When
		Before exercise:		
Sick ➤ Increased shortness of breath ➤ Coughing more than usual ➤ Increased wheezing ➤ Chest tightness ➤ Waking at night due to asthma ➤ Can do some, but not all, of the usual activities	Yellow Zone Peak Flow _____ (50% - 80% of best peak flow)	1 ➔ Add Quick Relief Meds		
		Medication	How Much	When
		2 ➔ If symptoms (& peak flow, if used) return to GREEN Zone after 1- hour after above treatment: Continue monitoring to be sure you stay in the GREEN Zone OR If symptoms (& peak flow, if used) don't return to GREEN Zone after 1-hour of above treatment:		
		Medication	How Much	When
Call your home care nurse or doctor in the next 24 hours if no improvement, Go to the hospital or Call 911				
Emergency ➤ Very short of breath ➤ Quick Relief meds have not helped ➤ Cannot do usual activities ➤ Symptoms are same or worse after 24 hours in the YELLOW Zone	Red Zone Peak Flow _____ (> 50% of best peak flow)	Go to the Hospital or Call 911 RIGHT AWAY or when Danger signs present: ➤ Trouble walking due to Shortness of breath ➤ Lips or fingernails are blue		

Patient Education										
	Date	Initials	Date	Initials	Date	Initials	Date	Initials	Date	Initials
➤ Medication Teaching										
➤ Flu Shot										
➤ Asthma Triggers										
➤ Tobacco Cessation										
➤ Activity										
➤ Energy Conservation										