

ASTHMA SYMPTOM DIARY -- PRE-VERBAL

Name: _____

Medical Record Number: _____

Date of Birth: _____

Month/Year: _____

Has a fever (mark date with *)

Date: _____

Cough frequency

- None.....0
- Occasional.....1
- Frequent.....2

Character of cough

- Dry.....1
- Productive or wet.....2
- Croupy (barking seal).....3

Nasal symptoms

- None.....0
- Stuffy.....1
- Clear Drainage.....2
- Yellow or green discharge.....3

Wheezing or forcing air out

- None.....0
- Little.....1
- Moderately bad.....2
- Severe.....3

Activity (playing, feeding, and vocalizing)

- Quite normal.....0
- Some difficulty.....1
- Moderate difficulty.....2
- Severe difficulty.....3

Retractions (sucking in of chest wall)

- None.....0
- Occasional.....1
- Part of day.....2
- Most of day.....3

Sleep disturbance due to cough, wheeze, or breathing problems

- None.....0
- Heard, does not wake.....1
- Awake.....2
- Unable to sleep.....3

Drugs (No. of doses/24 hours)

Week 1

Week 2

Week 3

Week 4

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

ASTHMA SYMPTOM DIARY -- VERBAL

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|---------------------------------------------------------------|------------------------|----------------|
| Name: | Medical Record Number: | Date of Birth: |
| Month/Year: | | |
| Has a fever (mark date with *) | | |
| Date: | | |
| Coughing | | |
| None.....0 | | |
| Occasional.....1 | | |
| Frequent.....2 | | |
| Character of cough | | |
| Dry.....1 | | |
| Productive or wet.....2 | | |
| Croupy (barking seal).....3 | | |
| Nasal symptoms | | |
| None.....0 | | |
| Stuffy.....1 | | |
| Clear Drainage.....2 | | |
| Yellow or green discharge.....3 | | |
| Wheezing or forcing air out | | |
| None.....0 | | |
| Little.....1 | | |
| Moderately bad.....2 | | |
| Severe.....3 | | |
| Activity level | | |
| Quite normal.....0 | | |
| Some difficulty.....1 | | |
| Moderate difficulty.....2 | | |
| Severe difficulty.....3 | | |
| Short of breath or chest tight | | |
| None.....0 | | |
| Occasional.....1 | | |
| Part of day.....2 | | |
| Most of day.....3 | | |
| Sleep disturbance due to cough, wheeze, or breathing problems | | |
| None.....0 | | |
| Heard, does not wake.....1 | | |
| Awake.....2 | | |
| Unable to sleep.....3 | | |
| Peak flow | | |
| Morning | | |
| After school | | |
| Drugs (No. of doses/24 hours) | Week 1 | Week 2 |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |

