ASTHMA DIARY

allergy foundation south africa

http://www.allergyfoundation.co.za

NAME

MEDICATION/ Dose

Controller		**Your doctor:**	
		Contact details	
Reliever		**Tel:**	
		Tel:	
Other			

fold

MONTH:_____

SYMPTOMS		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 - day																																
cough - night																																
wheeze / tight chest																																
used reliever																																
clinic / hospital visit for nebuliser																																
Controller	day																															
	night																															
other	day																															
	night																															

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