

Take this sheet to your next visit and fill out with your provider.

PATIENT NAME:	DOB:
DATE:	PRESCRIBER PHONE #:

 $\checkmark$  when indicated, use a spacer with your inhalers.

GREEN	<b>PEAK FLOW</b> Greater than: (80% or more of my best peak flow)			
<b>ZONE</b> <b>GOOD TO GO!</b> No asthma symptoms - able to go to school, play, and sleep without having symptoms like cough. <b>Avoid known triggers:</b>	Take controller medicines every day	Medicine	Amount	How often
	2. Take these medicines prescribed by the doctor (i.e. antihistamines & nasal sprays)	Medicine	Amount	How often
	<b>3.</b> Take this medicine 15 minutes before exercise (prime it first, if needed)	Medicine	Amount	How often

YELLOW	PEAK FLOW to	(50% to 79% or more of my best	peak flow)	Reep taking your Green Zone medicine	
LONE CAUTION!	Signs you are in the Yellow Zone:Waking at night due to wheeze or cough more than twice a monthCan't do every- day activitiesUsing quick relief medicine more than twice a week (excluding use before exercise)				
Asthma symptoms such as coughing, wheezing, shortness of breath or chest tightness may be occuring.	Start rescue medicine (prime it first, if needed)	Medicine	Amount	How often	
If not better in 24-48 hours, call your doctor or nurse.	If not improving or symptoms worsen, increase or add the following	Medicine	Amount	How often	

RED ZONE	PEAK FLOW Less than	: (50% of my best peak flow)			
DANGERI	Signs you are in the Red Zone:Severe shortness of breath, fast and hard breathing, and non-stop coughingThe skin may be pulling between the ribs or around the neck				
<b>DANGER!</b> Asthma symptoms may be severe or not responding to yellow zone treatments.	Increase rescue medicine	Medicine	Amount How often		
		ce while administering the treatments <b>Call</b> ight away. <b>OR Go to the nearest emergen</b>			

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