Name _____ Week Begining (Date) _____

Peak Flow Zones: Green Zone _____ Yellow Zone _____ Red Zone _____

Prescribed Medications (include dose and frequency) _____

Peak Flow Recording Times: _____ AM _____ PM

Day	Sunday				Monday				Tuesday				Wednesday				Thursday				Friday				Saturday			
Time		AM	PM			AM	PM			AM	PM			AM	PM			AM	PM			AM	PM			AM	PM	
Your Peak Flow Rates (liters/minute) 600																												
550																												
500																												
450																												
400																												
350																												
300																												
250																												
200																												
150																												
100																												
Changes in Medicine																												
Notes																												