Asthma Symptom Assessment

Date: **[Insert Date]**

Patient Name: **[Insert Patient Name]**

Patient ID: **[Insert Patient ID]**

Symptoms Assessment

Symptom	Frequency (None, Occasionally, Often, Always)	Severity (Mild, Moderate, Severe)
Cough	[Insert Frequency]	[Insert Severity]
Shortness of Breath	[Insert Frequency]	[Insert Severity]
Wheezing	[Insert Frequency]	[Insert Severity]
Chest Tightness	[Insert Frequency]	[Insert Severity]

Medication Use

Rescue Inhaler Usage: **[Insert Details]**

Controller Medication: **[Insert Details]**

Triggers

- [Insert Trigger 1]
- [Insert Trigger 2]
- [Insert Trigger 3]

Additional Notes

[Insert any additional relevant information]

Physician's Signature

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Dr. [Insert Doctor's Name]