Individualized Asthma Action Plan

Patient Name: [Patient's Name]

Date: [Date]

Doctor's Name: [Doctor's Name]

Doctor's Contact: [Doctor's Phone Number]

Asthma Control Assessment

[Assessment of current asthma control, e.g., frequency of symptoms, night awakenings]

Medications

Daily Controller Medications:

- [Medication Name] - [Dosage and Frequency]
- [Medication Name] - [Dosage and Frequency]

Rescue Medications:

- [Medication Name] - [Dosage and Instructions]

Personalized Action Steps

Green Zone - Good Control:

Your symptoms are under control. Continue taking your medications as prescribed.

Yellow Zone - Caution:

If you experience the following symptoms, follow these steps:

- [Symptom 1] - [Action]
- [Symptom 2] - [Action]

Red Zone - Medical Alert:

If you experience the following severe symptoms, seek medical attention immediately:

- [Severe Symptom 1] - [Emergency Action]

- [Severe Symptom 2] - [Emergency Action]

Trigger Management

Avoid the following triggers:

- [Trigger 1]
- [Trigger 2]

Follow-up Appointments

Next appointment scheduled for: [Date and Time]

For emergencies, call [Emergency Contact Information].

Signature:
[Doctor's Name]