Asthma Clinical Research Network
NIH/NHLBI

BAGS

PATIENT DIARY CARD

DRY

Patient ID: 1 ___ ___ ___ ___

Patient Initials: ___ ___ ___

Return Visit Number: ___ ___

Return Visit Date: ___ ___ / ___ ___ / ___ ___
month day year

dmonth / dday

	Day 1: ___/___ month day	Day 2: ___/___ month day	Day 3: ___/___ month day	Day 4: ___/___ month day	Day 5: ___/___ month day	Day 6: ___/___ month day	Day 7: ___/___ month day
MORNING EVALUATION							
01 1. Number of times that you woke up last night due to asthma							
02 2. Time of AM Peak Flow	::	::	::	::	::	::	::
03 3. AM Peak Flow (liters/min)** recorded first thing in the morning							
NIGHT-TIME EVALUATION							
04 4. Time of PM Peak Flow	::	::	::	::	::	::	::
05 5. PM Peak Flow (liters/min)** recorded before bedtime							
06 6. Total number of puffs of "scheduled" inhaler in past 24 hours							
07 7. Total number of puffs of "rescue" inhaler in past 24 hours							

** *Record the best of three attempts. Record 0 if you have taken any inhaler medication in the last two hours.*

SYMPTOMS*(to be completed before bedtime)*

Please rate the severity of your symptoms by filling in a number for each symptom for each day based on the symptom severity rating scale. Make a general decision about how severe each symptom was over the last 24 hours.

SYMPTOM SEVERITY RATING SCALE

0 = Absent No symptoms.
1 = Mild Symptom was minimally troublesome, i.e. not sufficient to interfere with normal daily activity or sleep.
2 = Moderate Symptom was sufficiently troublesome to interfere with normal daily activity or sleep.
3 = Severe Symptom was so severe as to prevent normal activity and/or sleep.

08 8. Shortness of Breath							
09 9. Chest Tightness							
10 10. Wheezing							
11 11. Cough							
12 12. Phlegm/Mucus							

PATIENT NOTES

DAILY NUMBER OF PUFFS

*Please tally the number of scheduled and rescue inhaler puffs **throughout the day**. Each night you should record the total number of puffs for the day for each inhaler on the reverse side of this card.*

	Day 1	*Day 2*	*Day 3*	*Day 4*	*Day 5*	*Day 6*	*Day 7*
scheduled inhaler							
rescue inhaler							

NON-STUDY MEDICATIONS

Please indicate any non-study medications that were taken during the week.

Medication	Dosage	Dates Taken	Reason

MEDICAL PROBLEMS

Please indicate any medical problems you have during the week. If you experience a significant asthma exacerbation or illness, contact study personnel within 72 hours.

Problem Description	Dates/Times	Comments

ADDITIONAL PEAK FLOW MEASUREMENTS

Please record any additional peak flow measurements taken due to worsening of your asthma.

Date	Time	Liters/Min	Comments