↓ Tear along perforated line ↓

Name: _____

Date: _____

Please mark the zones provided by your doctor in the next column by filling in the appropriate two boxes. For clarity, color each zone with green, yellow and red markers. See Instructions.

Date / Time	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
800																
750																
700																
650																
600																
550																
500																
450																
400																
350																
300																
250																
200																
150																
100																
50																

Spirometrics

Peak Flow Table

Date	Time	Reading	℞
/			
/			
/			