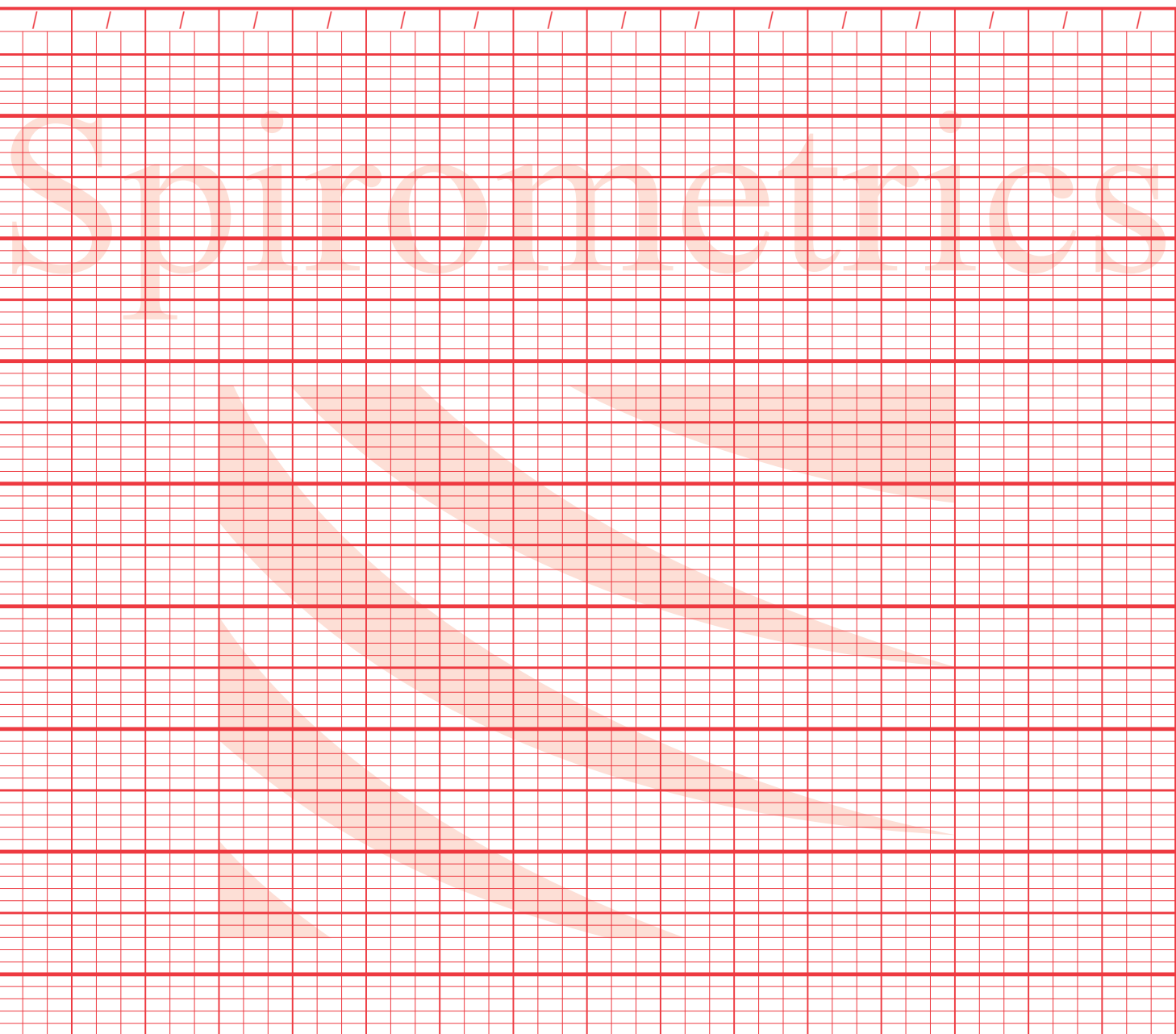


↑ Tear along perforated line ↑

Date
Time

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



Peak Flow Table

Date	Time	Reading	Rx
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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.

Rx Taken? y/n

Spirometrics



Notes

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