FOOD DIARY & SYMPTOMS TRACKER

DATE: _____ WEIGHT: _____ MOOD: ◯ Good ◯ Fair ◯ Poor SLEEP QUALITY: ◯ Good ◯ Fair ◯ Poor

TIME	ACTIVITY	SYMPTOMS	FOOD, DRINK, MEDICATION, SUPPLEMENT	AMOUNT
		◯ Headache ◯ Dizziness ◯ Fatigue ◯ Fainting ◯ Numbness ◯ Tingling ◯ Difficulty Concentrating ◯ Difficulty Sleeping ◯ Anxiety ◯ Irritability ◯ Depression ◯ Low Blood Pressure ◯ Rapid Pulse ◯ Muscle Pain ◯ Joint Pain ◯ Itching ◯ Rash ◯ Hives ◯ Abdominal Pain ◯ Back Pain ◯ Abdominal Swelling ◯ Gas ◯ Heartburn ◯ Nausea ◯ Vomiting ◯ Urgency ◯ Diarrhea ◯ Constipation ◯ Hemorrhoids ◯ Eyes Itching ◯ Eyes Swelling ◯ Dark Circles Around Eyes ◯ Nasal Congestion ◯ Runny Nose ◯ Mouth/Throat Itching ◯ Lip Swelling ◯ Tongue Swelling ◯ Facial Swelling ◯ Neck Swelling ◯ Swelling in Extremities ◯ Difficulty Swallowing ◯ Coughing ◯ Wheezing ◯ Difficulty Breathing ◯ Bad Breath ◯ Body Odor ◯ _____ ◯ _____	◯	
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