Diet !	Diary

Date starting:	To:	

Please record everything and anything you eat or drink including water, medications, supplements, smoking and alcohol, including amounts and times of day for each. Please be honest and accurate and do not change your eating habits. List any symptoms or changes you experience (ie. sleep disturbance, drowsiness, fatigue, headaches, depression, bloating, etc) and the time of day they occur. Please include basal body temperature taken orally upon waking before getting out of bed in the morning.

DAY1 Temperature: _____

TIME OF DAY	FOOD/DRINK	FEELINGS/ENERGY	BOWEL /URINE	NOTES

Temperature:	
	Temperature:

TIME OF DAY	FOOD/DRINK	FEELINGS/ENERGY	BOWEL /URINE	NOTES

DAY 3 Temperature: _____

TIME OF DAY	FOOD/DRINK	FEELINGS/ENERGY	BOWEL /URINE	NOTES

TIME OF DAY	FOOD/DRINK	FEELINGS/ENERGY	BOWEL /URINE	NOTES

DAY 4 Temperature: _____

TIME OF DAY	FOOD/DRINK	FEELINGS/ENERGY	BOWEL /URINE	NOTES

DAY 5 Temperature: _____

TIME OF DAY	FOOD/DRINK	FEELINGS/ENERGY	BOWEL /URINE	NOTES