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 from your norm, at this time. 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, if appropriate, taken orally upon waking before getting out of bed in the morning.

DAY 1 Temperature:

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

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

DAY 2 Temperature:

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

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

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

DAY 5 Temperature:

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