Date _____ Day _____

	AM	PM
Weight		
Temperature		
Blood Pressure		
Sugar Level		
Hours slept last night	Number of hours:	Sound Restless ☐
Naps taken today	How many?	Total hours:

Today's Weather

☐ Hot ☐ Sunny ☐ Damp
☐ Warm ☐ Cloudy ☐ Rainy
☐ Cool ☐ Overcast ☐ Snowy
☐ Cold ☐ Foggy ☐ Windy

Drugs / Medications

Qty AM	Qty PM	Description	Strength

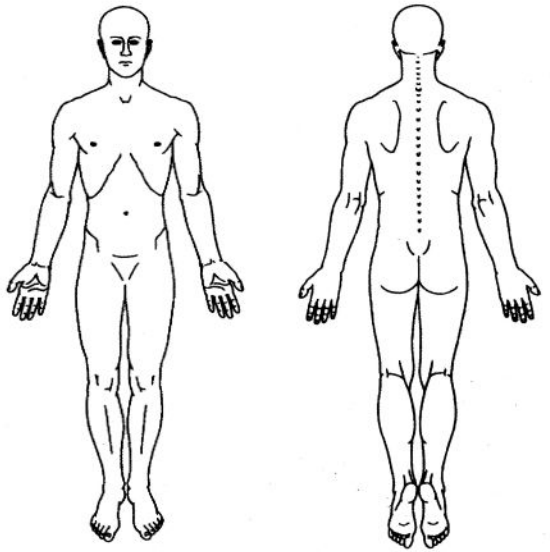
Vitamins / Herbs

Qty AM	Qty PM	Description	Strength

Physical Activity

Activity	Hours	Mins.

Pain / Discomfort / Skin Changes



Scale

1 Mild
2 Moderate
3 Severe
4 Very Severe
5 Worst Possible

Mark the area where the pain occurs with the number which corresponds to the intensity of the pain.

In general, today I felt:

☐ Good
☐ Fair
☐ Poor

Today's Conditions and Symptoms

Check the areas which apply and explain your conditions or symptoms in the space provided. See the *Symptoms Glossary* to help you describe your conditions.

☐ **Ears / Eyes / Nose**

☐ **Mouth / Throat**

☐ **Head / Neck / Back**

☐ **Shoulders / Arms / Hands**

☐ **Chest / Heart**

☐ **Respiratory System**

☐ **Digestive System**

☐ **Hips / Legs / Feet**

☐ **Male / Female Organs**

☐ **Skin**

☐ **Mood**

☐ **Other**

Comments

Today's Diet

In columns A&B, list the nutritional facts you wish to monitor (i.e. fat, calories, sodium, sugar, protein, etc.)

☐ **Breakfast**	A	B
Breakfast Totals		

☐ **Lunch**		
Lunch Totals		

☐ **Dinner**		
Dinner Totals		

☐ **Snacks**		
Snack Totals		

GRAND TOTALS FOR TODAY:

A	B