

Daily Record of Food Intake | Your diet may be the key to better health.



Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your health care professional for evaluation.

Name: _____

Day 1 - Date: _____

BREAKFAST Time: _____	LUNCH Time: _____	DINNER Time: _____
Meat & Dairy: _____	_____	_____
Vegetables & Fruits: _____	_____	_____
Breads, Cereals, & Grains: _____	_____	_____
Fats (butter, margarine, oils, etc.): _____	_____	_____
Candy, Sweets, & Junk Food: _____	_____	_____
Water Intake (fl. oz.): _____	_____	_____
Other Drinks: _____	_____	_____
MID-MORNING SNACK Time: _____	MID-DAY SNACK Time: _____	NIGHTTIME SNACK Time: _____
Snack: _____	_____	_____
Bowel Movements (# and consistency): _____	Hours of Sleep: _____	Quality of Sleep: (good) 1 2 3 4 5 (poor)
_____	_____	_____

Day 2 - Date: _____

BREAKFAST Time: _____	LUNCH Time: _____	DINNER Time: _____
Meat & Dairy: _____	_____	_____
Vegetables & Fruits: _____	_____	_____
Breads, Cereals, & Grains: _____	_____	_____
Fats (butter, margarine, oils, etc.): _____	_____	_____
Candy, Sweets, & Junk Food: _____	_____	_____
Water Intake (fl. oz.): _____	_____	_____
Other Drinks: _____	_____	_____
MID-MORNING SNACK Time: _____	MID-DAY SNACK Time: _____	NIGHTTIME SNACK Time: _____
Snack: _____	_____	_____
Bowel Movements (# and consistency): _____	Hours of Sleep: _____	Quality of Sleep: (good) 1 2 3 4 5 (poor)
_____	_____	_____

Day 3 - Date: _____

BREAKFAST Time: _____	LUNCH Time: _____	DINNER Time: _____
Meat & Dairy: _____	_____	_____
Vegetables & Fruits: _____	_____	_____
Breads, Cereals, & Grains: _____	_____	_____
Fats (butter, margarine, oils, etc.): _____	_____	_____
Candy, Sweets, & Junk Food: _____	_____	_____
Water Intake (fl. oz.): _____	_____	_____
Other Drinks: _____	_____	_____
MID-MORNING SNACK Time: _____	MID-DAY SNACK Time: _____	NIGHTTIME SNACK Time: _____
Snack: _____	_____	_____
Bowel Movements (# and consistency): _____	Hours of Sleep: _____	Quality of Sleep: (good) 1 2 3 4 5 (poor)
_____	_____	_____

Notes: _____

