

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: _____

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: _____

Snack: _____

Bowel Movements (# and consistency): _____

LUNCH Time: _____

MID-DAY SNACK Time: _____

Hours of Sleep: _____

DINNER Time: _____

NIGHTTIME SNACK Time: _____

Quality of Sleep: (good) 1 2 3 4 5 (poor)

Day 2 - Date: _____

BREAKFAST 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: _____

Snack: _____

Bowel Movements (# and consistency): _____

LUNCH Time: _____

MID-DAY SNACK Time: _____

Hours of Sleep: _____

DINNER Time: _____

NIGHTTIME SNACK Time: _____

Quality of Sleep: (good) 1 2 3 4 5 (poor)

Day 3 - Date: _____

BREAKFAST 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: _____

Snack: _____

Bowel Movements (# and consistency): _____

LUNCH Time: _____

MID-DAY SNACK Time: _____

Hours of Sleep: _____

DINNER Time: _____

NIGHTTIME SNACK Time: _____

Quality of Sleep: (good) 1 2 3 4 5 (poor)

Notes: _____