Date _____ Day _____

Today's Weather

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

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

Drugs / Medications

Qty AM	Qty PM	Description	Strength

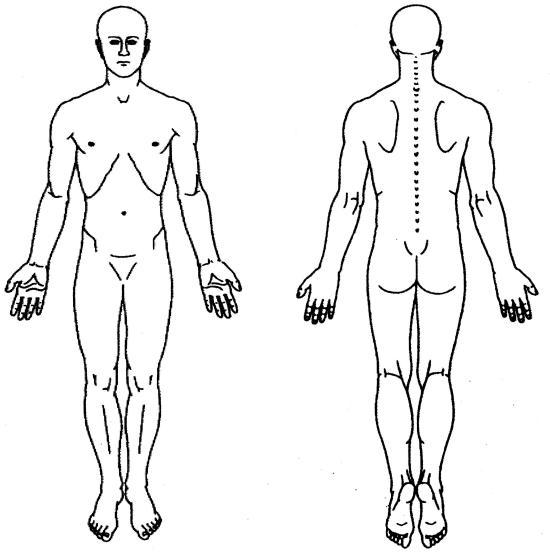
Vitamins / Herbs

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