

Name: \_\_\_\_\_

Date:	Food/Drink Consumed	Any Reactions/Symptoms?	Notes
Breakfast			
Lunch			
Dinner			
Snacks/Other			
<b>Other Information</b> Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: Bowel Movement <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: Energy 1-10 (10 best) AM_____ Midday_____ PM_____ General Mood:		Day in Cycle ♀: _____ PMS ♀: Hours of sleep last night: _____ Activities (work, etc.)/Other:	

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