allergy foundation south africa
www.allergyfoundation.co.za

HEALTHY LIVING

WEEKLY **FOOD & SYMPTOM** RECORD/DIARY

DAY/DATE							
Day of Menstrual Cycle (if applicable)							
Symptoms after a night's sleep							
BREAKFAST							
Symptoms							
IN-BETWEEN SNACK/DRINK							
Symptoms							
LUNCH							
Symptoms							
IN-BETWEEN SNACK/DRINK							
Symptoms							
SUPPER							
Symptoms							
LATE EVENING SNACK/DRINK							
Symptoms							
Medication/Supplements taken (if applicable)							
Stool Pattern & Frequency							
Quality of Sleep							
Level of Stress							
Activity Level							
Possible External Contributors to Symptoms							

Name: _____

COMPLETE THE DIARY FOR A MINIMUM OF 14 DAYS

1. Record all foods & beverages consumed, as well as other e.g., gum chewed within the selected days, including:
    i. Time of consumption
    ii. Details about each food item / meal:
        1. Recipe / Ingredients used
        2. Cooking /Preparation method
        3. Seasoning (ingredients)
        4. Brand name of a packaged product, with ingredient list
    iii. Describe your symptoms, as well as the severity thereof:
        1. 0 = No symptoms
        2. 1 (+) = Mild
        3. 2 (++) = Moderate
        4. 3 (+++) = Severe