Daily Diet and Medication Form

Date :_____

Name :_____ Email:_____

Mobile :_____ Profession:_____

Gender:_____ Date of Birth:_____

Address :_____

Weight:_____ Height:_____

Pulse Rate:_____ B.P:_____ Date of the test _____

If you have high sugar level/ Diabetes fill the info below :

Blood Sugar level (Fasting) : _____ Blood sugar Level (PP) : _____ Date of the Test _____

If you have high cholesterol level please fill the info below :

Total Cholesterol _____ HDL _____ LDL _____ TG _____ Date of the test _____

Your Daily Diet :

Early morning ,the first thing you eat/drink _____

For example medicine/a glass of warm water/ honey and lemon with water, or tea or coffee or fruit juice or wheatgrass

Breakfast _____

For example : Parantha with curd or achar/ sabji chapatti/bread butter/omelets/ boiled eggs sprouts/soaked dry fruits /idli/dosa/vada / fruit juice/ whole fruit like banana, orange etc.).

10 a.m-12 noon:* (Mid morning Snacks)

_____

For example : biscuits/water/tea/coffee/herbal tea/juice /fruits/tea/snack any other eatable

Lunch :* _____

For example : Rice/dal/chapatti/sabji/salad/curd/pickle/ papad /sweet dish/non veg item any thing else

4Pm - 7p.m:* (Evening Snacks)

_____

For Example : tea/coffee/samosa/kachori/snack/bread/other refreshment/ water /medicine /fruits, pizza /soup/any other eatable.

8 p.m - 10p.m:* (Dinner)

_____

_____

For example : Rice/Dal/chapatti/sabji/non-veg/ sweet dish/ fruits / vegetables /salad/dry fruits anything else any medicine after dinner

Late night snack :_____

water/any other eatable that you take before retiring to bed.

Physical Activity:

Morning:*_____

walk in the park/ lawn/yoga/aerobics/swimming /walk the dog/household chores/workout in the gym/ gardening/walk to drop the child to school bus/temple/grocery stores

Afternoon:*_____

kitchen work/ post lunch walk/ Evening walk /park/ lawn/yoga/aerobics/swimming/any other sport/walk the dog/household chores/yoga

Evening and Night :* _____

After dinner walk in the park/ lawn/yoga/aerobics/swimming/any other sport/walk the dog/house hold chores

Sleep Pattern :*

· Sleeping time at night _____

·Wake up time _____

·Regular/disturbed sleep during night

·Day time nap : (Time and duration) Morning and evening

Family History :*_____

If there has been a any kind of disease in the family history like diabetes, heart diseases, asthma, high /low BP, or other diseases.

Medications Taken::*

Disease : _____

Medications: Name of the medication once/twice/thrice and before/ after meals.

_____

_____

Duration: For how long have you been taking this medicine_____

Unusual Symptoms or Discomfort*

Mention if you feel some discomfort that you generally do not feel on any normal day?

_____

_____

Any other problem (medical canditions) you would like to share?

_____

_____

_____

_____

Other information:_____

_____

Signature

*** In Doctor's Chamber : •Keep your mobile phone in switch off mode.**
•Time to explain your problem :5 minutes
•Time to understand the solution :5 minutes