

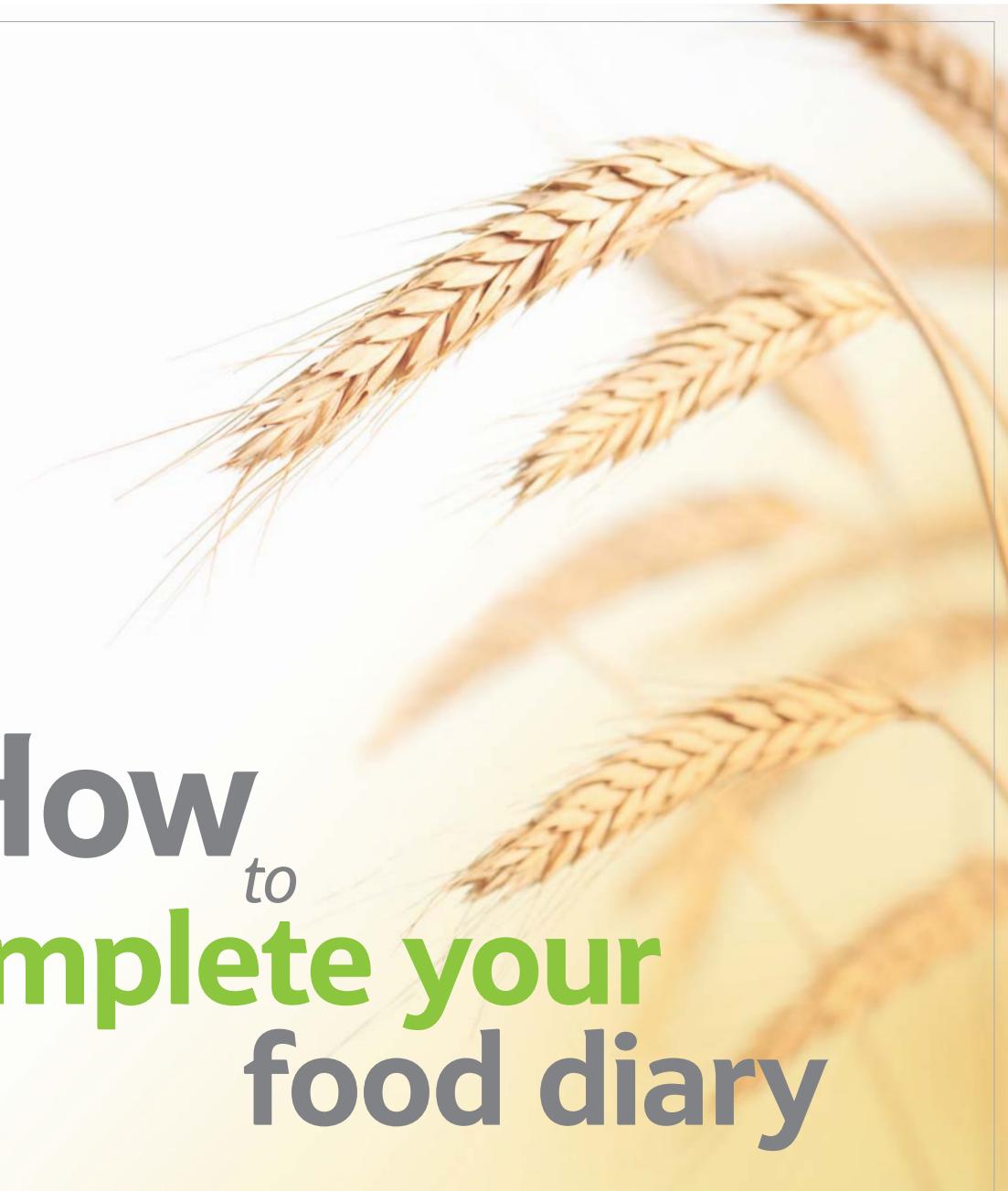
PHARMACY SERVICES

Food Intolerance Service

FOOD DIARY



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How to complete your food diary

Please complete your food diary as accurately as possible.

The more information you provide the better help you will be given on your eating choices and patterns for the future.

- Complete your food diary for 7 days – 5 week days and the weekend.**
- Please try to complete all 7 days in as much detail as possible.**
The more information you provide, the more you can benefit from this service.

At the end of the food diary there is a section for you to make any additional notes if you need to, for example, if you were unwell on any of the days then you can make a note of it here so the Nutritional Therapist is aware.

What do I need to put in my food diary?

- Do not be afraid to be honest. For example, if you ate 3 chocolate bars in one day or drank 3 cans of cola, please note that down. We are not here to judge; only to help you.
- In the 'WHERE CONSUMED' column, give as much information as possible i.e. do not simply write 'restaurant or home', please specify, for example 'sitting down at the dining table, in front of the TV, at office desk'.
- If you have a hot drink like coffee, please note if it's caffeine or decaffeinated.
- If you use sugar or other similar sweeteners, please include this.
- Be specific rather than generic about the types of foods you list. So if you ate fruit – please say what type, e.g. '2 apples' or '1 banana'. Please do not just put down 'fruit'.
- If you eat low fat versions of foods, e.g. yoghurt or skimmed/semi-skimmed milk – please mention this.
- If any foods (bought or home grown) are organic, please mention.
- If you make your own blend of something you commonly eat – please mention. For example, homemade muesli, e.g. almonds, oats, pumpkin seeds, berries.
- Try to be specific about quantities. For example '6 brazil nuts' as opposed to just 'brazil nuts', or '1 chicken breast' as opposed to 'chicken breast'.
- If you eat non-dairy or non-meat versions of some foods - please also note this. For example, 'soya yoghurt' or 'Quorn mince'.
- If you eat a snack or meal with a brand name e.g. 'Kellogg's corn flakes' – please note this.
- If you eat something raw – please make it distinct from cooked food, e.g. raw salad with cooked runner beans.
- If something is homemade, please mention this. However if you eat take-away food or go out for dinner, please also note this.
- Note if an item is a 'free-from' version of a common food e.g. wheat free cereal bar or milk free ice-cream and so on.
- Please also list drinks – e.g. tea, wine, fruit juice. Be very specific – e.g. if you drank a cordial with sweeteners - put that, or if you drank sugar free cold pressed apple juice – put that.
- If you drank water, please put in glasses, bottles or litres and include details such as 'still' or 'sparkling'.
- At the end of each day please make a total note of the bowel movement (s) you experienced that day by putting a number in the bottom column (even if this is none – please put '0'). So for example, on Monday you may put '2' and on Thursday you may put '1').



Name: _____

Date: _____

Food Diary DAY 1

Time	Food & Drink Consumed	Where Consumed
		<i>(for example, sitting down at the dining table, in front of TV)</i>

Please tick any of the following symptoms that you experienced:



Itchy skin	Excessive catarrh or mucus	
Rashes	Bloating	
Tiredness	Excessive flatulence	
Brain fog	Constipation	
Headache	Diarrhoea	
Sinus problems/nasal congestion	Water retention	
Generally feeling under the weather	Stomach cramps	
Aggravation of existing medical issues, such as joint discomfort		
Aggravation of existing skin issues, such as eczema		
Other:		

Number of bowel movements: _____

Name: _____

Date: _____

Food Diary DAY 2

Time	Food & Drink Consumed	Where Consumed
		<i>(for example, sitting down at the dining table, in front of TV)</i>

Please tick any of the following symptoms that you experienced:



Itchy skin	Excessive catarrh or mucus	
Rashes	Bloating	
Tiredness	Excessive flatulence	
Brain fog	Constipation	
Headache	Diarrhoea	
Sinus problems/nasal congestion	Water retention	
Generally feeling under the weather	Stomach cramps	
Aggravation of existing medical issues, such as joint discomfort		
Aggravation of existing skin issues, such as eczema		
Other:		

Number of bowel movements: _____

Name: _____

Date: _____

Food Diary DAY 3

Time	Food & Drink Consumed	Where Consumed
		<i>(for example, sitting down at the dining table, in front of TV)</i>

Please tick any of the following symptoms that you experienced:



Itchy skin	Excessive catarrh or mucus	
Rashes	Bloating	
Tiredness	Excessive flatulence	
Brain fog	Constipation	
Headache	Diarrhoea	
Sinus problems/nasal congestion	Water retention	
Generally feeling under the weather	Stomach cramps	
Aggravation of existing medical issues, such as joint discomfort		
Aggravation of existing skin issues, such as eczema		
Other:		

Number of bowel movements: _____

Name: _____

Date: _____

Food Diary DAY 4

Time	Food & Drink Consumed	Where Consumed
		<i>(for example, sitting down at the dining table, in front of TV)</i>

Please tick any of the following symptoms that you experienced:



Itchy skin	Excessive catarrh or mucus	
Rashes	Bloating	
Tiredness	Excessive flatulence	
Brain fog	Constipation	
Headache	Diarrhoea	
Sinus problems/nasal congestion	Water retention	
Generally feeling under the weather	Stomach cramps	
Aggravation of existing medical issues, such as joint discomfort		
Aggravation of existing skin issues, such as eczema		
Other:		

Number of bowel movements: _____

Name: _____

Date: _____

Food Diary DAY 5

Time	Food & Drink Consumed	Where Consumed
		<i>(for example, sitting down at the dining table, in front of TV)</i>

Please tick any of the following symptoms that you experienced:



Itchy skin	Excessive catarrh or mucus	
Rashes	Bloating	
Tiredness	Excessive flatulence	
Brain fog	Constipation	
Headache	Diarrhoea	
Sinus problems/nasal congestion	Water retention	
Generally feeling under the weather	Stomach cramps	
Aggravation of existing medical issues, such as joint discomfort		
Aggravation of existing skin issues, such as eczema		
Other:		

Number of bowel movements: _____

Name: _____

Date: _____

Food Diary DAY 6

Time	Food & Drink Consumed	Where Consumed
		<i>(for example, sitting down at the dining table, in front of TV)</i>

Please tick any of the following symptoms that you experienced:



Itchy skin	Excessive catarrh or mucus	
Rashes	Bloating	
Tiredness	Excessive flatulence	
Brain fog	Constipation	
Headache	Diarrhoea	
Sinus problems/nasal congestion	Water retention	
Generally feeling under the weather	Stomach cramps	
Aggravation of existing medical issues, such as joint discomfort		
Aggravation of existing skin issues, such as eczema		
Other:		

Number of bowel movements: _____

Name: _____

Date: _____

Food Diary DAY 7

Time	Food & Drink Consumed	Where Consumed
		<i>(for example, sitting down at the dining table, in front of TV)</i>

Please tick any of the following symptoms that you experienced:



Itchy skin	Excessive catarrh or mucus	
Rashes	Bloating	
Tiredness	Excessive flatulence	
Brain fog	Constipation	
Headache	Diarrhoea	
Sinus problems/nasal congestion	Water retention	
Generally feeling under the weather	Stomach cramps	
Aggravation of existing medical issues, such as joint discomfort		
Aggravation of existing skin issues, such as eczema		
Other:		

Number of bowel movements: _____

Food Diary NOTES



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If you have any further questions relating to this or any other Tesco Pharmacy service, please speak to your Tesco Pharmacy team.