**3-Day Food Intake Record**

**Baseline Question:** Are you taking any **supplements?** This includes all over-the-counter and prescribed supplements (e.g. multivitamin, fish oil, etc) \_\_\_Yes \_\_\_No

**If yes,** please list all supplements in the table below.

**All Follow-up Visits:** Have you had any changes to your supplements since your last visit? \_\_\_Yes \_\_\_No **If Yes,** please indicate in the table below which supplements you have started or stopped taking, or if the dose or frequency has changed for any current supplements.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Supplement** | **Dose** | **Frequency** | **Start Date** | **Stop Date** | **Reason for Taking Supplement** |
| e.g. Vitamin D | 1000 IU | 1x/day | Oct. 2010 | - | Bone health (osteoporosis) |
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**DAILY FOOD RECORD – Day One**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / / \_\_\_ Weekday \_\_\_Weekend

Please list all food, beverages & water. Estimate all food/drink amounts accurately.

|  |  |  |
| --- | --- | --- |
| TIME  (am/pm) | FOOD, BEVERAGE & detailed description of item  (Please include brand name, if possible) | QUANTITY  (e.g. tsp., cup, oz., each) |
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Was this a typical day? If not, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you take all your usual medications and supplements as prescribed? \_\_\_Yes \_\_\_No

**DAILY FOOD RECORD – Day Two**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / / \_\_\_ Weekday \_\_\_Weekend

Please list all food, beverages & water. Estimate all food/drink amounts accurately.

|  |  |  |
| --- | --- | --- |
| TIME  (am/pm) | FOOD, BEVERAGE & detailed description of item  (Please include brand name, if possible) | QUANTITY  (e.g. tsp., cup, oz., each) |
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Was this a typical day? If not, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you take all your usual medications and supplements as prescribed? \_\_\_Yes \_\_\_No

**DAILY FOOD RECORD – Day Three**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / / \_\_\_ Weekday \_\_\_Weekend

Please list all food, beverages & water. Estimate all food/drink amounts accurately.

|  |  |  |
| --- | --- | --- |
| TIME  (am/pm) | FOOD, BEVERAGE & detailed description of item  (Please include brand name, if possible) | QUANTITY  (e.g. tsp., cup, oz., each) |
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Was this a typical day? If not, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you take all your usual medications and supplements as prescribed? \_\_\_Yes \_\_\_No