


Health Diary

Date: _____

Food / Drink	Quantity	Time of Day
		

Water <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Vitamins <input type="checkbox"/>	Weigh-In _____ weight _____ time of day
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Activity	Duration

Notes

