health journal

TEMP: _____ (°C or °F)
♡RATE: _____ BPM
BLOOD O_2: _____ %

Today's date: _____ (mm/dd/yyyy)

MEDICATIONS:

Name of medication	What's the prescribed dose?	How often do you take it?	What do you take it for?

SIDE EFFECTS

Any side effects experienced lately? (Circle) YES / NO
If yes, what? From which medication?

_____
_____
_____
_____

WHAT I ATE:

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

BEVERAGES:

WEIGHT: _____ (any unit)
HEIGHT: _____ (any unit)

HOURS OF SLEEP:

from last night

_____ hours _____ mins.

OTHER CONCERNS?

SYMPTOMS

Feeling good (mentally? physically?) today? (Circle) YES / NO
If no, please list what's bothering you today and at what time: