Patient: _____ **Diet Diary**

Please fill out this diet diary for **three days** and be specific with what you eat and drink. Include ingredients and amounts of servings. Please also report symptoms you experience after eating or drinking.

Days	Breakfast	Snack	Lunch	Snack	Dinner	Snack	How many Bowel Movements?	Consistency of Bowel Movement
Day 1								
Symptoms after eating or drinking								
Day 2								
Symptoms after eating or drinking								
Day 3								
Symptoms after eating or drinking								

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