Daily Symptom Tracker

One page a day for symptoms, sleep, medicines and possible triggers.

Fill in a page each evening. At the end of the week, copy your numbers into My week.

DATE

Tuesday, March 10

Example

1 Symptoms

Up to five. Circle one number, tick when it happened.

SYMPTOM	SEVERITY 0 to 10 (none … worst)	TIME OF DAY: Morning	Afternoon	Evening	Night	HOW LONG
Headache	7	☐	☑	☑	☐	*About 5 hours*
Fatigue	6	☑	☑	☐	☐	*Most of the day*
Nausea	4	☐	☐	☑	☐	*1 hour*
Brain fog	3	☑	☐	☐	☐	*Until noon*
		☐	☐	☐	☐	

2 Sleep

Last night.

Went to bed	*12:40 am*
Woke up	*6:30 am*
Hours of sleep	*About 6*
Times I woke up	*2*
How I slept	Poorly ● ○ ○ ○ Well

3 Medicines

Include anything taken as needed.

MEDICINE OR SUPPLEMENT	TIME	TAKEN	MISSED
Birth control pill	*8:00 am*	☑	☐
Vitamin D	*8:00 am*	☐	☑
Pain reliever	*2:30 pm*	☑	☐
		☐	☐

4 Possible triggers

Tick anything that was different from a usual day.

- ☑ Poor sleep
- ☐ Stress
- ☑ Skipped a meal
- ☐ New food
- ☐ Alcohol
- ☐ Caffeine
- ☐ Weather change
- ☐ More activity than usual
- ☐ Long screen time
- ☑ Period
- ☑ Missed medicine
- ☐ Illness
- ☐ Travel

Something else _____

5 What helped

Rest, heat, a walk, a medicine, anything you tried.

Dark room and a cold pack. Lay down after work.

6 Notes

Food, activity, mood, questions, anything else.

Headache started around 2 pm at work. Light bothered me, so I left early.

Ask: could the headaches be linked to my period?

DATE

Day 1 of 7

1 Symptoms

Up to five. Circle one number, tick when it happened.

SYMPTOM	SEVERITY 0 to 10 (none … worst)	TIME OF DAY: Morning	Afternoon	Evening	Night	HOW LONG
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	

2 Sleep

Last night.

Went to bed _____

Woke up _____

Hours of sleep _____

Times I woke up _____

How I slept Poorly ○ ○ ○ ○ Well

3 Medicines

Include anything taken as needed.

MEDICINE OR SUPPLEMENT	TIME	TAKEN	MISSED
		☐	☐
		☐	☐
		☐	☐
		☐	☐

4 Possible triggers

Tick anything that was different from a usual day.

☐ Poor sleep ☐ Stress ☐ Skipped a meal ☐ New food ☐ Alcohol ☐ Caffeine ☐ Weather change ☐ More activity than usual

☐ Long screen time ☐ Period ☐ Missed medicine ☐ Illness ☐ Travel Something else _____

5 What helped

Rest, heat, a walk, a medicine, anything you tried.

6 Notes

Food, activity, mood, questions, anything else.

DATE

Day 2 of 7

1 Symptoms

Up to five. Circle one number, tick when it happened.

SYMPTOM	SEVERITY 0 to 10 (none … worst)	TIME OF DAY: Morning	Afternoon	Evening	Night	HOW LONG
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	

2 Sleep

Last night.

Went to bed _____

Woke up _____

Hours of sleep _____

Times I woke up _____

How I slept Poorly ○ ○ ○ ○ Well

3 Medicines

Include anything taken as needed.

MEDICINE OR SUPPLEMENT	TIME	TAKEN	MISSED
		☐	☐
		☐	☐
		☐	☐
		☐	☐

4 Possible triggers

Tick anything that was different from a usual day.

☐ Poor sleep ☐ Stress ☐ Skipped a meal ☐ New food ☐ Alcohol ☐ Caffeine ☐ Weather change ☐ More activity than usual

☐ Long screen time ☐ Period ☐ Missed medicine ☐ Illness ☐ Travel Something else _____

5 What helped

Rest, heat, a walk, a medicine, anything you tried.

6 Notes

Food, activity, mood, questions, anything else.

DATE

Day 3 of 7

1 Symptoms

Up to five. Circle one number, tick when it happened.

SYMPTOM	SEVERITY 0 to 10 (none … worst)	TIME OF DAY: Morning	Afternoon	Evening	Night	HOW LONG
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	

2 Sleep

Last night.

Went to bed _____

Woke up _____

Hours of sleep _____

Times I woke up _____

How I slept Poorly ○ ○ ○ ○ Well

3 Medicines

Include anything taken as needed.

MEDICINE OR SUPPLEMENT	TIME	TAKEN	MISSED
		☐	☐
		☐	☐
		☐	☐
		☐	☐

4 Possible triggers

Tick anything that was different from a usual day.

☐ Poor sleep ☐ Stress ☐ Skipped a meal ☐ New food ☐ Alcohol ☐ Caffeine ☐ Weather change ☐ More activity than usual

☐ Long screen time ☐ Period ☐ Missed medicine ☐ Illness ☐ Travel Something else _____

5 What helped

Rest, heat, a walk, a medicine, anything you tried.

6 Notes

Food, activity, mood, questions, anything else.

DATE

Day 4 of 7

1 Symptoms

Up to five. Circle one number, tick when it happened.

SYMPTOM	SEVERITY 0 to 10 (none … worst)	TIME OF DAY: Morning	Afternoon	Evening	Night	HOW LONG
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	

2 Sleep

Last night.

Went to bed _____

Woke up _____

Hours of sleep _____

Times I woke up _____

How I slept Poorly ○ ○ ○ ○ Well

3 Medicines

Include anything taken as needed.

MEDICINE OR SUPPLEMENT	TIME	TAKEN	MISSED
		☐	☐
		☐	☐
		☐	☐
		☐	☐

4 Possible triggers

Tick anything that was different from a usual day.

☐ Poor sleep ☐ Stress ☐ Skipped a meal ☐ New food ☐ Alcohol ☐ Caffeine ☐ Weather change ☐ More activity than usual

☐ Long screen time ☐ Period ☐ Missed medicine ☐ Illness ☐ Travel Something else _____

5 What helped

Rest, heat, a walk, a medicine, anything you tried.

6 Notes

Food, activity, mood, questions, anything else.

DATE

Day 5 of 7

1 Symptoms

Up to five. Circle one number, tick when it happened.

SYMPTOM	SEVERITY 0 to 10 (none … worst)	TIME OF DAY: Morning	Afternoon	Evening	Night	HOW LONG
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	

2 Sleep

Last night.

Went to bed _____

Woke up _____

Hours of sleep _____

Times I woke up _____

How I slept Poorly ○ ○ ○ ○ Well

3 Medicines

Include anything taken as needed.

MEDICINE OR SUPPLEMENT	TIME	TAKEN	MISSED
		☐	☐
		☐	☐
		☐	☐
		☐	☐

4 Possible triggers

Tick anything that was different from a usual day.

☐ Poor sleep ☐ Stress ☐ Skipped a meal ☐ New food ☐ Alcohol ☐ Caffeine ☐ Weather change ☐ More activity than usual

☐ Long screen time ☐ Period ☐ Missed medicine ☐ Illness ☐ Travel Something else _____

5 What helped

Rest, heat, a walk, a medicine, anything you tried.

6 Notes

Food, activity, mood, questions, anything else.

DATE

Day 6 of 7

1 Symptoms

Up to five. Circle one number, tick when it happened.

SYMPTOM	SEVERITY 0 to 10 (none … worst)	TIME OF DAY: Morning	Afternoon	Evening	Night	HOW LONG
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	

2 Sleep

Last night.

Went to bed _____

Woke up _____

Hours of sleep _____

Times I woke up _____

How I slept Poorly ○ ○ ○ ○ Well

3 Medicines

Include anything taken as needed.

MEDICINE OR SUPPLEMENT	TIME	TAKEN	MISSED
		☐	☐
		☐	☐
		☐	☐
		☐	☐

4 Possible triggers

Tick anything that was different from a usual day.

☐ Poor sleep ☐ Stress ☐ Skipped a meal ☐ New food ☐ Alcohol ☐ Caffeine ☐ Weather change ☐ More activity than usual

☐ Long screen time ☐ Period ☐ Missed medicine ☐ Illness ☐ Travel Something else _____

5 What helped

Rest, heat, a walk, a medicine, anything you tried.

6 Notes

Food, activity, mood, questions, anything else.

DATE

Day 7 of 7

1 Symptoms

Up to five. Circle one number, tick when it happened.

SYMPTOM	SEVERITY 0 to 10 (none … worst)	TIME OF DAY: Morning	Afternoon	Evening	Night	HOW LONG
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	
	0 1 2 3 4 5 6 7 8 9 10	☐	☐	☐	☐	

2 Sleep

Last night.

Went to bed _____

Woke up _____

Hours of sleep _____

Times I woke up _____

How I slept Poorly ○ ○ ○ ○ Well

3 Medicines

Include anything taken as needed.

MEDICINE OR SUPPLEMENT	TIME	TAKEN	MISSED
		☐	☐
		☐	☐
		☐	☐
		☐	☐

4 Possible triggers

Tick anything that was different from a usual day.

☐ Poor sleep ☐ Stress ☐ Skipped a meal ☐ New food ☐ Alcohol ☐ Caffeine ☐ Weather change ☐ More activity than usual

☐ Long screen time ☐ Period ☐ Missed medicine ☐ Illness ☐ Travel Something else _____

5 What helped

Rest, heat, a walk, a medicine, anything you tried.

6 Notes

Food, activity, mood, questions, anything else.

My week

Copy each symptom's number from the daily pages. Side by side, changes are easier to see.

WEEK OF _____ TO _____

1 Severity each day

Write a symptom on each row, then its number from 0 to 10.

DAY	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
DATE							
Hours of sleep							
Missed a medicine	☐	☐	☐	☐	☐	☐	☐

2 Triggers that came up most

3 What helped most

4 New or different this week

Symptoms you had not noticed before, and when they started.

FOR MY NEXT APPOINTMENT

Questions for my doctor, and anything I want to understand or change.