

# DAILY DIET AND MEDICATION FORM

## 72 Hrs- Residential Diabetes Tour

(27th-29th April-2018)



Date: \_\_\_\_\_

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Mobile: \_\_\_\_\_ Profession: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ DOB- \_\_\_\_\_

WHATSAPP NUMBER\*: \_\_\_\_\_ (Mandatory to provide)

Address For Correspondence: \_\_\_\_\_

Your preferred Language to receive Books (conditions apply) : Hindi or English \_\_\_\_\_

Do you smoke: \_\_\_\_\_ Do you Drink: \_\_\_\_\_ Any Allergy (Food): \_\_\_\_\_

Vegetarian: \_\_\_\_\_ Non- Vegetarian: \_\_\_\_\_

10.Weight: \_\_\_\_\_ 11.Height: \_\_\_\_\_ 13.B.P: \_\_\_\_\_

14.Name of the Medical Condition / Diabetes : \_\_\_\_\_

For how long have you been suffering from Medical Condition / Diabetes: \_\_\_\_\_

**\*If Diabetic please fill the information below.**

HbA1c: \_\_\_\_\_ Blood Sugar level (Fasting) : \_\_\_\_\_ Blood sugar Level (PP) : \_\_\_\_\_ Date of the Test: \_\_\_\_\_

**15. If you have high cholesterol level please fill the info below :**

Total Cholesterol \_\_\_\_\_ HDL \_\_\_\_\_ LDL \_\_\_\_\_ TG \_\_\_\_\_ Date of the test: \_\_\_\_\_

**Any other Medical Condition /conditions:** \_\_\_\_\_

**Any Other Unusual Symptom or Discomfort that you do not have in any other normal day or activity**

### PHYSICAL-ACTIVITY:

Morning:\* \_\_\_\_\_

Afternoon:\* \_\_\_\_\_

Evening and Night :\* \_\_\_\_\_

### SLEEP PATTERN :\*

· Wake up time \_\_\_\_\_ Sleeping time at night: \_\_\_\_\_

· Regular/disturbed sleep during night \_\_\_\_\_

· Day time nap (Time and duration) Morning and evening : \_\_\_\_\_

**YOUR DAILY DIET:**

Early morning, the first thing you eat/drink

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Breakfast

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10 a.m-12 noon:\* ( Mid-morning Snacks)

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Lunch:

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4Pm - 7p.m:\* (Evening Snacks)

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8 p.m - 10p.m:\* (Dinner )

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Late night snack:

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**MEDICATION AND DOSAGE CHART**

<b>DISEASE /MEDICAL CONDITION</b>	<b>MEDICATION / INSULIN TAKEN</b>	<b>Morning Time &amp; Dose</b>	<b>Afternoon Time &amp; Dose</b>	<b>Evening Time &amp; Dose</b>	<b>Night Time &amp; Dose</b>	<b>Before Sleep Dose</b>

**Important Note:**

- 1. Please Provide Pictures of the Medications Taken By You Along With This Form**
- 2. Diabetes Type 1 Patients to provide last 15 Days Sugar readings along with Insulin Dosage.**
- 3. Please Use The Space Below For Any Other Important Information That Is Not Mentioned In The Form Which You Would Like To Bring To Our Notice:**

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**Signature**