

Date: ____/____/____

DAILY FOOD AND SYMPTOM DIARY

Time Interval	Actual Time	Breastfeeding Duration (Minutes per Feed)	Urine	Stool	Other Infant Intake (Food or Fluid)	Mother's Food & Fluid Intake	Infant Symptoms—Behavior (1-5 scale, see below) Describe physical symptoms (e.g., rash, cough, congestion, runny nose, vomiting, diarrhea)
12—1 am							
1—2 am							
2—3 am							
3—4 am							
4—5 am							
5—6 am							
6—7 am							
7—8 am							
8—9 am							
9—10 am							
10—11am							
11—12noon							
12—1 pm							
1—2 pm							
2—3 pm							
3—4 pm							
4—5 pm							
5—6 pm							
6—7 pm							
7—8 pm							
8—9 pm							
9—10 pm							
10—11 pm							
11—12 midnight							

Scale:
 1 = asleep
 2 = quiet awake
 3 = slightly fussy

4 = consolable crying
 5 = unconsolable crying

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