# Brain fog tracker

Next Chapter Wellness OC | Name (optional): _____

Record episodes for 1-2 weeks. Bring these notes and your medication list to your provider.
Patterns are not a diagnosis. Do not change prescribed medicines without your provider.

Severity: 1 = mild, 2 = noticeable, 3 = interfered with tasks. Use a new entry for each episode.

**Entry 1 Date:** _____ **Time / duration:** _____

What happened / activity: _____
Severity (1-3): _____ Effect on your day: _____
Sleep: ____ hours Quality / waking: _____
Meals, snacks & drinks (include times / skipped meals): _____
_____
Medication / supplement changes (name, dose, date, or none): _____
_____
Other notes (stress, hot flashes, illness): _____

**Entry 2 Date:** _____ **Time / duration:** _____

What happened / activity: _____
Severity (1-3): _____ Effect on your day: _____
Sleep: ____ hours Quality / waking: _____
Meals, snacks & drinks (include times / skipped meals): _____
_____
Medication / supplement changes (name, dose, date, or none): _____
_____
Other notes (stress, hot flashes, illness): _____

**Entry 3 Date:** _____ **Time / duration:** _____

What happened / activity: _____
Severity (1-3): _____ Effect on your day: _____
Sleep: ____ hours Quality / waking: _____
Meals, snacks & drinks (include times / skipped meals): _____
_____
Medication / supplement changes (name, dose, date, or none): _____
_____
Other notes (stress, hot flashes, illness): _____

Questions for my healthcare provider: _____

_____

_____

Sudden confusion, difficulty speaking, or new weakness: call 911. Do not wait to track it.

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**Entry 4 Date:** _____ **Time / duration:** _____

What happened / activity: _____
Severity (1-3): _____ Effect on your day: _____
Sleep: ____ hours Quality / waking: _____
Meals, snacks & drinks (include times / skipped meals): _____
_____
Medication / supplement changes (name, dose, date, or none): _____
_____
Other notes (stress, hot flashes, illness): _____

**Entry 5 Date:** _____ **Time / duration:** _____

What happened / activity: _____
Severity (1-3): _____ Effect on your day: _____
Sleep: ____ hours Quality / waking: _____
Meals, snacks & drinks (include times / skipped meals): _____
_____
Medication / supplement changes (name, dose, date, or none): _____
_____
Other notes (stress, hot flashes, illness): _____

**Entry 6 Date:** _____ **Time / duration:** _____

What happened / activity: _____
Severity (1-3): _____ Effect on your day: _____
Sleep: ____ hours Quality / waking: _____
Meals, snacks & drinks (include times / skipped meals): _____
_____
Medication / supplement changes (name, dose, date, or none): _____
_____
Other notes (stress, hot flashes, illness): _____

Questions for my healthcare provider: _____

_____

_____

Sudden confusion, difficulty speaking, or new weakness: call 911. Do not wait to track it.