Day:					
			How do you feel after eating i.e. normal / bloated / pain / reflux / Itchy / watery eyes or runny nose / heart rate change / heart burn /full / hungry / vague / focused / tired / energised /other		
Time of day	**Food / Liquid Item** please list everything that goes onto your mouth and is swallowed	**Amount** (in grams or cups or ml or glass or handful or tsp etc)	5 mins later	1hr later	3 hrs later