Low Cholesterol Diet Chart

Patient name: _____ **Age:** _____ **Sex:** _____

Week number: _____

Day	Breakfast	Morning snack	Lunch	Afternoon snack	Snack	Evening snack
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						

Week number: _____

Day	Breakfast	Morning snack	Lunch	Afternoon snack	Snack	Evening snack
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						

Additional notes

Healthcare professional's information	
Name:	License number:
Contact details:	Signature: