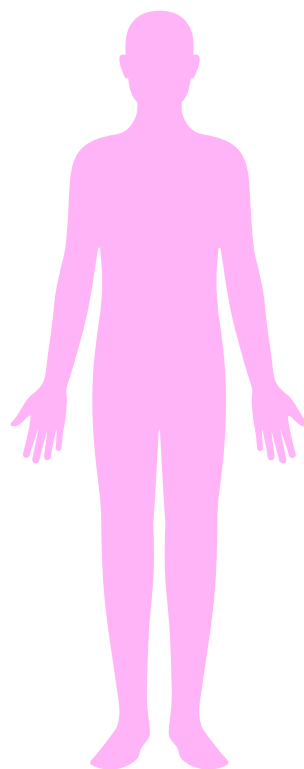


Lupus Tracker

Symptoms	
<input type="checkbox"/>	None
<input type="checkbox"/>	Confusion / Brain Fog
<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Light Sensitivity
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Headache
<input type="checkbox"/>	Fever
<input type="checkbox"/>	Hair Loss
<input type="checkbox"/>	Mouth Sores
<input type="checkbox"/>	Nose Sores
<input type="checkbox"/>	Raynaud's
<input type="checkbox"/>	Rash
<input type="checkbox"/>	Joint Stiffness
<input type="checkbox"/>	Swollen Ankles
<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Other _____
<input type="checkbox"/>	Other _____

Date	___/___/___
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Note Location Of Pain And/Or Rash



Stress	
Level of Stress	___ / 10

Sleep	
Hours of Sleep	
Quality of Sleep	___ / 10

Treatments Used	
<input type="checkbox"/>	None
<input type="checkbox"/>	Rest
<input type="checkbox"/>	Gentle Exercise
<input type="checkbox"/>	Heating Pad or Hot Shower
<input type="checkbox"/>	Ice Pack Or Cold Compress
<input type="checkbox"/>	Drink Water
<input type="checkbox"/>	Medication_____
<input type="checkbox"/>	Medication_____
<input type="checkbox"/>	Other _____

Potential Flare-Up Triggers	
<input type="checkbox"/>	None
<input type="checkbox"/>	Medications
<input type="checkbox"/>	Light Exposure
<input type="checkbox"/>	Infection or Illness
<input type="checkbox"/>	Stress
<input type="checkbox"/>	Lack of Sleep
<input type="checkbox"/>	Physical Exertion
<input type="checkbox"/>	Menstrual Changes
<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	Smoke Exposure
<input type="checkbox"/>	Weather or Heat
<input type="checkbox"/>	Other _____

Food and Drinks	
Breakfast	
Lunch	
Dinner	
Snacks	
Drinks	

Additional Notes	