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

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