Dietary record

NuSTEPS: Nutritional Status and dietary Effects on Phosphorous metabolism and clinical Symptoms in Hypophosphatasia

Instructions for completing the dietary record:

- Please do not change your usual diet and keep the dietary record on 7 consecutive days (including weekends)
- Enter all food and beverages consumed (including snacks, candies or the like) in the tables provided
- Please describe the food as precisely as possible
  - Specify the variety (e.g. pizza salami, strawberry yogurt)
  - Name the brand name/manufacturer of the products, including beverages (incl. mineral water)
  - Pay attention to the fat content of the food and write it down (milk 1,8% or 3,8%)
- Please indicate the quantities consumed as precisely as possible
  - If possible, weigh the quantities with a kitchen scale,
  - Otherwise use household sizes (grams, 1 tbsp, 1 handful...)
  - Indicate the condition of the food when the quantity was determined (raw, cooked)
- Please name the recipe for home-cooked food, do not forget spices
- Try to complete the diary while you are eating (also outside the home) and avoid completing the diary out of memory

⇒ **Please answer the questions about your state of health every evening**

Example: (Brand names and manufacturers are not mentioned to avoid advertising)

Quantities (grams, household sizes)	Food/Beverages
1	multi-grain roll
20g	butter
1 slice	Emmentaler
20g	strawberry jam
1	banana
1 cup (250ml)	coffee
1 (50g)	chocolate bar with peanuts
2 glasses (à 250ml)	mineral water
125g (raw)	spaghetti
150g (raw)	ground meat (beef)
1	scallion
100g	canned tomatoes
1 tbsp.	colza oil
1/2 tsp.	salt
5 leaves	basil
1/2 tsp.	pepper
1 glass (250ml)	cola
2 glasses (à 250ml)	mineral water
1 piece (150g)	apple crumble cake
1 cup (150ml)	cappuccino
1 heaped tsp.	sugar
2 slices	brown bread
1 slice	mortadella
20g	butter
1 piece (30g)	camembert
1 cup (250ml)	peppermint tea

1. Day, Date: _____

1. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

1. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

1. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

1. Day

Did your diet on the 1. day correspond to your usual diet?
☐ Yes ☐ No

If not, what were the particularities?

Did you have any complaints on the 1. day?
☐ Yes ☐ No

If yes, which? Please check:

☐ joint pain	☐ loss of appetite	☐ fatigue	☐ nausea	☐ mental complaints
☐ joint swelling	☐ sleep disorders	☐ tired legs	☐ diarrhea	☐ concentration disorders
☐ muscle pain	☐ muscle cramps	☐ constipation	☐ migraine	☐ brain fog

Other: _____

Did any complaints occur immediately after meal?
☐ Yes ☐ No

If yes, which and after which meal?

Did you take medication on the 1. day?
☐ Yes ☐ No

If yes, which? Please list:

---

2. Day, Date: _____

2. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

2. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

2. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

2. Day

Did your diet on the 2. day correspond to your usual diet?
☐ Yes ☐ No

If not, what were the particularities?

Did you have any complaints on the 2. day?
☐ Yes ☐ No

If yes, which? Please check:

☐ joint pain	☐ loss of appetite	☐ fatigue	☐ nausea	☐ mental complaints
☐ joint swelling	☐ sleep disorders	☐ tired legs	☐ diarrhea	☐ concentration disorders
☐ muscle pain	☐ muscle cramps	☐ constipation	☐ migraine	☐ brain fog

Other: _____

Did any complaints occur immediately after meal?
☐ Yes ☐ No

If yes, which and after which meal?

Did you take medication on the 2. day?
☐ Yes ☐ No

If yes, which? Please list:

---

3. Day, Date: _____

3. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

3. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

3. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

3. Day

Did your diet on the 3. day correspond to your usual diet?
☐ Yes ☐ No

If not, what were the particularities?

Did you have any complaints on the 3. day?
☐ Yes ☐ No

If yes, which? Please check:

☐ joint pain	☐ loss of appetite	☐ fatigue	☐ nausea	☐ mental complaints
☐ joint swelling	☐ sleep disorders	☐ tired legs	☐ diarrhea	☐ concentration disorders
☐ muscle pain	☐ muscle cramps	☐ constipation	☐ migraine	☐ brain fog

Other: _____

Did any complaints occur immediately after meal?
☐ Yes ☐ No

If yes, which and after which meal?

Did you take medication on the 3. day?
☐ Yes ☐ No

If yes, which? Please list:

---

4. Day, Date: _____

4. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

4. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

4. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

4. Day

Did your diet on the 4. day correspond to your usual diet?
☐ Yes ☐ No

If not, what were the particularities?

Did you have any complaints on the 4. day?
☐ Yes ☐ No

If yes, which? Please check:

☐ joint pain	☐ loss of appetite	☐ fatigue	☐ nausea	☐ mental complaints
☐ joint swelling	☐ sleep disorders	☐ tired legs	☐ diarrhea	☐ concentration disorders
☐ muscle pain	☐ muscle cramps	☐ constipation	☐ migraine	☐ brain fog

Other: _____

Did any complaints occur immediately after meal?
☐ Yes ☐ No

If yes, which and after which meal?

Did you take medication on the 4. day?
☐ Yes ☐ No

If yes, which? Please list:

---

5. Day, Date: _____

5. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

5. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

5. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

5. Day

Did your diet on the 5. day correspond to your usual diet?
☐ Yes ☐ No

If not, what were the particularities?

Did you have any complaints on the 5. day?
☐ Yes ☐ No

If yes, which? Please check:

☐ joint pain	☐ loss of appetite	☐ fatigue	☐ nausea	☐ mental complaints
☐ joint swelling	☐ sleep disorders	☐ tired legs	☐ diarrhea	☐ concentration disorders
☐ muscle pain	☐ muscle cramps	☐ constipation	☐ migraine	☐ brain fog

Other: _____

Did any complaints occur immediately after meal?
☐ Yes ☐ No

If yes, which and after which meal?

Did you take medication on the 5. day?
☐ Yes ☐ No

If yes, which? Please list:

---

6. Day, Date: _____

6. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

6. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

6. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

6. Day

Did your diet on the 6. day correspond to your usual diet?
☐ Yes ☐ No

If not, what were the particularities?

Did you have any complaints on the 6. day?
☐ Yes ☐ No

If yes, which? Please check:

☐ joint pain	☐ loss of appetite	☐ fatigue	☐ nausea	☐ mental complaints
☐ joint swelling	☐ sleep disorders	☐ tired legs	☐ diarrhea	☐ concentration disorders
☐ muscle pain	☐ muscle cramps	☐ constipation	☐ migraine	☐ brain fog

Other: _____

Did any complaints occur immediately after meal?
☐ Yes ☐ No

If yes, which and after which meal?

Did you take medication on the 6. day?
☐ Yes ☐ No

If yes, which? Please list:

---

7. Day, Date: _____

7. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

7. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

7. Day

Quantity (grams, household sizes)	Food/Beverages

Quantity (grams, household sizes)	Food/Beverages

7. Day

Did your diet on the 7. day correspond to your usual diet?
☐ Yes ☐ No

If not, what were the particularities?

Did you have any complaints on the 7. day?
☐ Yes ☐ No

If yes, which? Please check:

☐ joint pain	☐ loss of appetite	☐ fatigue	☐ nausea	☐ mental complaints
☐ joint swelling	☐ sleep disorders	☐ tired legs	☐ diarrhea	☐ concentration disorders
☐ muscle pain	☐ muscle cramps	☐ constipation	☐ migraine	☐ brain fog

Other: _____

Did any complaints occur immediately after meal?
☐ Yes ☐ No

If yes, which and after which meal?

Did you take medication on the 7. day?
☐ Yes ☐ No

If yes, which? Please list:

Notes:

Subject number:

If you have any questions, please contact:

Katinka Kühn
Institute of Food Science and Human Nutrition
Gottfried Wilhelm Leibniz Universität Hannover
Am Kleinen Felde 30
30167 Hannover, Germany
Tel.: +49-511-762 5969
Fax: +49-511-762 5729
Email: kuehn@nutrition.uni-hannover.de