PATIENT DIARY

Date _____

Patient # _____

Your next appointment is _____

Patient Name _____
Last First Middle

Instructions: Complete ___ diaries anytime prior to your next appointment. Mark the description which best describes your level of function for each 30-minute period. If you are resting but not asleep during part of the day, try to engage in some activity such as standing or walking in order to accurately record your level of function. Your spouse or another constant companion may complete this form if necessary. **Put a check in the appropriate box.**

Definition of Terms

On: Good motor function

Off: Able to move slowly or not at all

On with Dyskinesia: Able to move but troubled by involuntary or unintentional movements

Please bring completed form with you to your next appointment.

Circle Your Meal Times	Tablet Taken	Asleep	ON	OFF	ON with Dyskinesia	Circle Your Meal Times	Tablet Taken	Asleep	ON	OFF	ON with Dyskinesia	Circle Your Meal Times	Tablet Taken	Asleep	ON	OFF	ON with Dyskinesia
Midnight						8:00						4:00					
:30						:30						:30					
1:00						9:00						5:00					
:30						:30						:30					
2:00						10:00						6:00					
:30						:30						:30					
3:00						11:00						7:00					
:30						:30						:30					
4:00						Noon						8:00					
:30						:30						:30					
5:00						1:00						9:00					
:30						:30						:30					
6:00						2:00						10:00					
:30						:30						:30					
7:00						3:00						11:00					
:30						:30						:30					