BLOOD GLUCOSE RECORD

Patient Name:

Date of Birth **Phone#**

Email Address

BLOOD GLUCOSE GOALS:	
Fasting	
1 hour after meal	
2 hours after meal	
Before meal	

Please Test _____times per day _____days per week

Usual testing times:Fasting and 2 hours after meals or as directed

	Date	Breakfast		Lunch		Dinner		bed time	Exercise time	Comments
		before	2 hrs after	before	2 hrs after	before	2 hrs after			
Blood Glucose										
Medication										
Blood Glucose										
Medication										
Blood Glucose										
Medication										
Blood Glucose										
Medication										
Blood Glucose										
Medication										
Blood Glucose										
Medication										
Blood Glucose										
Medication										

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