



Patient Name: _____ DOB: _____

Month: _____ EDC: _____ Meter: _____

Phone # (H): _____ Phone # (W): _____

Next Appointment: _____

MD (circle one): Dr. Doedon Dr. Laedtke Dr. Leebaw Dr. Mattison Dr. Ruegemer

Post Meal Testing (circle one): 1 hour 2 hours

OB MD: _____

BLOOD GLUCOSE RECORD GDM / TYPE 1 / TYPE 2

DATE:	Urine Ketones	Insulin	BLOOD GLUCOSE		Insulin	BLOOD GLUCOSE		Insulin	BLOOD GLUCOSE		Insulin	Bed Time	Comments
			Before Breakfast	After Breakfast		Before Noon	After Noon		Before Supper	After Supper			

Diabetes Medications: _____

Blood Glucose Parameters:
 Fasting Blood Sugar < 95 One Hour After Meal < 140 Two hours after meal < 120