



Patient Name: _____ DOB: _____

Month: _____ EDC: _____ Meter: _____

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

Next Appointment: _____

MD (circle one): Dr. Chow Dr. Doeden Dr. Laedtke 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			BLOOD GLUCOSE			BLOOD GLUCOSE			Bed Time	Comments
			Before Breakfast	After Breakfast	Insulin	Before Noon	After Noon	Insulin	Before Supper	After Supper	Insulin		

Diabetes Medications: _____

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