Blood Sugar Record

Name ___________________________ Phone number _______________________
Doctor’s name ______________________ Phone number ______________________
When to test: ______________________ Target blood sugar _____ to _____ mg/dl

Diabetes medicines (include name and dose): ____________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Special instructions for patients with Type 1 Diabetes: Remember to check Ketones if your glucose is greater than 300. Record in same area as your glucose (N = Negative, TR = Trace, SM = Small, MOD = Moderate, LG = Large).

<table>
<thead>
<tr>
<th>Date</th>
<th>Fasting AM/ Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
<th>Bedtime</th>
<th>Middle of the Night</th>
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WEXNER MEDICAL CENTER
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