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).

Date	Fasting AM/ Breakfast		Lunch		Dinner		Bedtime		Middle of the Night	
	Blood Sugar	Insulin	Blood Sugar	Insulin	Blood Sugar	Insulin	Blood Sugar	Insulin	Blood Sugar	Insulin

Date	Fasting AM/ Breakfast		Lunch		Dinner		Bedtime		Middle of the Night	
	Blood Sugar	Insulin	Blood Sugar	Insulin	Blood Sugar	Insulin	Blood Sugar	Insulin	Blood Sugar	Insulin

Talk to your healthcare provider if you have any questions about your care.

To print copies of this record, visit **go.osu.edu/pted2263**.

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