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****Bring this form to EVERY visit for your provider to review.****

****Test your Blood Sugar levels EVERY DAY, 4 times each day.****

Patient's Name:

Chart #:

BLOOD SUGAR LOG

CALL THE OFFICE IF:

- > You have **any** fasting blood sugars (before breakfast) greater than 150
- > You have **any** 2 hour values greater than 200

	<i>Day 1</i>	<i>Day 2</i>	<i>Day 3</i>	<i>Day 4</i>	<i>Day 5</i>	<i>Day 6</i>	<i>Day 7</i>	Normal Ranges
Date:								
Insulin-AM								
Insulin-PM								
**Do not eat anything after midnight the night before you test your "before breakfast/fasting level"								
**fasting before breakfast								Less than 95
2 hours after breakfast								Less than 121
2 hours after lunch								Less than 121
2 hours after dinner								Less than 121
	<i>Day 8</i>	<i>Day 9</i>	<i>Day 10</i>	<i>Day 11</i>	<i>Day 12</i>	<i>Day 13</i>	<i>Day 14</i>	Normal Ranges
Date:								
Insulin-AM								
Insulin-PM								
**Do not eat anything after midnight the night before you test your "before breakfast/fasting level"								
**fasting before breakfast								Less than 95
2 hours after breakfast								Less than 121
2 hours after lunch								Less than 121
2 hours after dinner								Less than 121