



4414 Lake Boone Trail, Suite 205, Raleigh, NC 27607  
 781 Avenet Ferry Road, Suite 106, Holly Springs, NC 27540  
 Phone (919) 788-4444 \* Fax (919) 788-4464  
[www.centreobgyn.com](http://www.centreobgyn.com)

**\*\*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>	<b>Normal Ranges</b>
<b>Date:</b>								
<b>Insulin-AM</b>								
<b>Insulin-PM</b>								
<b>**Do not eat anything after midnight the night before you test your "before breakfast/fasting level"</b>								
<b>**fasting before breakfast</b>								Less than 95
<b>2 hours after breakfast</b>								Less than 121
<b>2 hours after lunch</b>								Less than 121
<b>2 hours after dinner</b>								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>	<b>Normal Ranges</b>
<b>Date:</b>								
<b>Insulin-AM</b>								
<b>Insulin-PM</b>								
<b>**Do not eat anything after midnight the night before you test your "before breakfast/fasting level"</b>								
<b>**fasting before breakfast</b>								Less than 95
<b>2 hours after breakfast</b>								Less than 121
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