Name: ______________________________ DOB: _______________

BLOOD SUGAR LOG

Please check your blood sugars 7 times a day, before and after meals and at bedtime and record on the log below. Please bring log to your next doctor's appointment.

Date	Before Breakfast	2-hr After Breakfast	Before Lunch	2-hr After Lunch	Before Supper	2-hr After Supper	Bedtime

MRN: ______________________________

DIABESITY MD