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HOUSTON CENTER FOR MATERNAL FETAL MEDICINE
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DIABETES DIARY FOR PREGNANCY

Patient's Name: _____ Date of Birth: _____

Date Started:	**Please call for any questions:**	
Target glucose: Fasting blood glucose 90 and below 2 hours after meals 120 and below	Please indicate insulin medication: □ None □ Metformin □ Insulin (*List type of Insulin*): _____	**Insulin:**
1. Fill in your blood glucose levels below. 2. Exercise 30 minutes at least 3-5 times per week. 3. Bring your diary and diabetes supplies to your appointments		

	Before Breakfast	Before Dinner	At Bedtime
NPH			
Regular			

Date	**Fasting Glucose**	**2 hours after breakfast**	**2 hours after lunch**	**2 hours after dinner**	**Minutes of exercise**	**Notes**

PLEASE SEND WEEKLY BLOOD SUGARS TO NURSE
Fax: (832) 209-2733 or E-mail: rhoda@drgei.com