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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				
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					

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