

For Weekly Blood Sugar Record (Patients requiring Insulin)
Fingerstick Blood Sugar Record

Label

Patient Name: _____ Patient's Phone Number: _____

DOB: _____ Best Time To Reach Patient: _____

Name and amount of insulin taking: _____

Office Fax#: 336-713-7255

Date/Time	Before Breakfast	Breakfast Insulin Dose	After Breakfast	Before Lunch	Lunch Insulin Dose	After Lunch	Before Dinner	Dinner Insulin Dose	After Dinner	Bed Time

Comments/ Questions