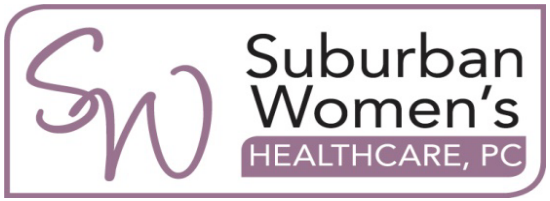
Name : _____

DOB: _____



Blood Sugar Log

Goals:

** **Fasting (less than 95)**

** **2 Hours after a meal (less than 120)**

Date	Day	Fasting	Breakfast	Lunch	Dinner	Medication	Comments
	Monday						
	Tuesday						
	Wednesday						
	Thursday						
	Friday						
	Saturday						
	Sunday						
	Monday						
	Tuesday						
	Wednesday						
	Thursday						
	Friday						
	Saturday						
	Sunday						

**** **Please Fax this sheet to our office at (716) 876-7342 on Monday Morning**