

# CAPSTONE HEALTH PLAN

*A Special Plan for Special Needs*

## BLOOD SUGAR DIARY

*Please complete this portion with your healthcare provider.*

Name: \_\_\_\_\_ Month: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

When do I need to test my blood sugar:     Before meals     2 hours after meals     At bedtime     At 3 am

My blood sugar target before meals is: \_\_\_\_\_ after meals \_\_\_\_\_ at bedtime \_\_\_\_\_

My diabetes medications are: \_\_\_\_\_

When do I need to call my healthcare provider? \_\_\_\_\_

Date	Blood Sugar Before Breakfast	Diabetes Medicine	2 Hours After Breakfast	Blood Sugar Before Lunch	Diabetes Medicine	2 Hours After Lunch	Blood Sugar Before Dinner	Diabetes Medicine	2 Hours After Dinner	Blood Sugar At Bedtime	Diabetes Medicine	Blood Sugar At 3 am	Comments
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													

Date	Blood Sugar Before Breakfast	Diabetes Medicine	2 Hours After Breakfast	Blood Sugar Before Lunch	Diabetes Medicine	2 Hours After Lunch	Blood Sugar Before Dinner	Diabetes Medicine	2 Hours After Dinner	Blood Sugar At Bedtime	Diabetes Medicine	Blood Sugar At 3 am	Comments
11													
12													
13													
14													
15													
16													
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18													
19													
20													
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*This information is not intended as a substitute for your provider's opinion or care. For complete diagnosis and treatment consult your health care provider.*