# Blood Glucose Chart

Name _____ Patient ID# _____

Doctor _____

Please measure and record your blood glucose readings in chart below. If the medication you take varies, be sure to record type and amount. Bring this form to the office when you come for your next evaluation.

**Week Start Date:**

| MONDAY | Breakfast | | Lunch | | Snack | | Dinner | | Bedtime |
|---|---|---|---|---|---|---|---|---|---|
| | Before | After | Before | After | Before | After | Before | After | |
| Time | | | | | | | | | |
| Glucose Level | | | | | | | | | |
| Medication | | | | | | | | | |
| **TUESDAY** | **Breakfast** | | **Lunch** | | **Snack** | | **Dinner** | | **Bedtime** |
| | Before | After | Before | After | Before | After | Before | After | |
| Time | | | | | | | | | |
| Glucose Level | | | | | | | | | |
| Medication | | | | | | | | | |
| **WEDNESDAY** | **Breakfast** | | **Lunch** | | **Snack** | | **Dinner** | | **Bedtime** |
| | Before | After | Before | After | Before | After | Before | After | |
| Time | | | | | | | | | |
| Glucose Level | | | | | | | | | |
| Medication | | | | | | | | | |
| **THURSDAY** | **Breakfast** | | **Lunch** | | **Snack** | | **Dinner** | | **Bedtime** |
| | Before | After | Before | After | Before | After | Before | After | |
| Time | | | | | | | | | |
| Glucose Level | | | | | | | | | |
| Medication | | | | | | | | | |
| **FRIDAY** | **Breakfast** | | **Lunch** | | **Snack** | | **Dinner** | | **Bedtime** |
| | Before | After | Before | After | Before | After | Before | After | |
| Time | | | | | | | | | |
| Glucose Level | | | | | | | | | |
| Medication | | | | | | | | | |
| **SATURDAY** | **Breakfast** | | **Lunch** | | **Snack** | | **Dinner** | | **Bedtime** |
| | Before | After | Before | After | Before | After | Before | After | |
| Time | | | | | | | | | |
| Glucose Level | | | | | | | | | |
| Medication | | | | | | | | | |
| **SUNDAY** | **Breakfast** | | **Lunch** | | **Snack** | | **Dinner** | | **Bedtime** |
| | Before | After | Before | After | Before | After | Before | After | |
| Time | | | | | | | | | |
| Glucose Level | | | | | | | | | |
| Medication | | | | | | | | | |

Comments _____

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