

BLOOD GLUCOSE RECORD

Patient Name: _____	BLOOD GLUCOSE GOALS: Fasting _____ 1 hour after meal _____ 2 hours after meal _____ Before meal _____
Date of Birth _____ Phone# _____	
Email Address _____	
Check your Physician/Provider:	

- | | |
|--|---|
| <input type="checkbox"/> Richard Guthrie, MD | <input type="checkbox"/> Belinda Childs, ARNP |
| <input type="checkbox"/> Phil Challans, MD | <input type="checkbox"/> Jolene Grothe, ARNP |
| <input type="checkbox"/> Jeremiah Nelson, MD | <input type="checkbox"/> Diana Guthrie, ARNP |
| | <input type="checkbox"/> Debbie Hinnen, ARNP |

	Date:	Breakfast		Lunch		Dinner		bed time	Exercise time	Comments
		before	2 hrs after	before	2 hrs after	before	2 hrs after			
Blood Glucose										
Medication										
Blood Glucose										
Medication										
Blood Glucose										
Medication										
Blood Glucose										
Medication										
Blood Glucose										
Medication										
Blood Glucose										
Medication										
Blood Glucose										
Medication										

Nurse Email: nurse@madiabetesa.com

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other: _____