Patient Name _____

Gestational Diabetes Monitoring Record

	Before Breakfast	After Breakfast	After Lunch	After Dinner
Date:				
Result				
Date:				
Result				
Date:				
Result				
Date:				
Result				
Date:				
Result				
Date:				
Result				
Date:				
Result				

- **Please send/report your glucoses to the office every week.**
- **If you come to the office for weekly or twice weekly testing bring your glucoses with you <u>EVERY</u> visit.**

Target Blood sugars:
Fasting: <95
2 hours After Meals: <120

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