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BLOOD GLUCOSE TESTING LOG

Patient's Name _____ **Phone number** _____

Diabetic Pills (name) _____

Month / Year	Pre Breakfast BG/ Insulin Dose	Pre Lunch BG / Insulin Dose	Pre Dinner BG / Insulin Dose	Bedtime BG / Insulin Dose	Basal Insulin AM / PM	Comments
1						
2						
3						
4						
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