



# Blood Glucose Monitoring Log

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

Date of Birth (or MRN) \_\_\_\_\_

or patient label

### Upload to MyChart

A photo of this completed form is acceptable.

*(Preferred Method)*



### Mail or FAX to:

Christine Olinghouse, FNP  
6640 SW Redwood Lane  
Portland, OR 97224  
FAX: 971-713-7240  
Phone: 503-221-0161 ext.2327

### Medications

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Please list glucose numbers and add medication/insulin units in separate box.

| Date | Before Breakfast |              | Before Lunch |              | Before Dinner |              | Bedtime | 3am | Comments |
|------|------------------|--------------|--------------|--------------|---------------|--------------|---------|-----|----------|
|      | BLOOD SUGAR      | INSULIN DOSE | BLOOD SUGAR  | INSULIN DOSE | BLOOD SUGAR   | INSULIN DOSE |         |     |          |
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## Blood Sugar Goals

Fasting & before meals  
70-80 to 130

2 hours after meals  
140-180

Bedtime  
Over 120-150

