

BLOOD SUGAR RESULT	TS	LOG	ì
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		FAX: 217-463-4060	EMAIL: diabetes@myhorizonhealth.org
Name (required)	DOB (required)	Pho	ne:
Week of (required):			
Mealtime Insulin:	Bedtime Insulin:	Cori	rection Factor:

	Breakfast		Lunch		Dinner		Bedtime		Other/Snack			Comments				
Day Date	Time	Pre	Carbs	Time	Pre	Carbs	Time	Pre	Carbs	Time	Pre	Carbs	Time	Pre	Carbs	Diet, Exercise, Ketones,
Mon			Illisuiili			IIISUIIII			IIISUIIII			IIISUIIII			Insulin	
Tues																
Wed																
Thurs																
Fri																
Sat																
Sun																