DATE:_____ WEIGHT_____

	AM	PM
TEMPERATURE		
BLOOD PRESSURE/HEART RATE		

	BREAKFAST	LUNCH	DINNER	BEDTIME
BLOOD SUGAR				
INSULIN DOSE				

MEDICATIONS				
NAME OF MEDICINE	TIME			
	DOSAGE (mg)			

*Use the other side of this page to document any questions or findings that you think are out of the ordinary for this day. You may refer to it at a later visit or if a problem should arise.