COALVILLE & KAMAS
HEALTH CENTERS

GLUCOSE TESTING LOG

PATIENT NAME:_____ DOB____/____/_____

Day	Breakfast			Lunch			Dinner			Comment
Date	Before	Insulin	After	Before	Insulin	After	Before	Insulin	After	
Mon										
Tue										
Wed										
Thu										
Fri										
Sat										
Sun										

Day	Breakfast			Lunch			Dinner			Comment
Date	Before	Insulin	After	Before	Insulin	After	Before	Insulin	After	
Mon										
Tue										
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