DIABETES™ Care Group

Fax: 228-207-4274

Name:	**Doctor:**	**Blood sugar goals**	
Month:	**Year:**	**Goal before meal:**	**80-120**
Medication:		**Goal 2 hours after meal:**	**<140 good** **< 160 ok** **>180 too high**

DATE	BREAKFAST		LUNCH		DINNER		BEDTIME	COMMENTS
	BEFORE	2hr. After	BEFORE	2hr. After	BEFORE	2 hr. After		