# PATIENT NAME: _____

WEEK BEGINNING: _____ (DATE)

| | Insulin Injections | | | | | Monitoring Blood Glucose | | | | | | | | Remarks Activity, illness, diet changes, time of hypos (noting blood glucose and treatment). |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Type of Insulin | Units given | | | | Breakfast | | Lunch | | Dinner | | Before Supper or Bed | Over night | |
| | | Breakfast | Lunch | Dinner | Before Bed | Before | After | Before | After | Before | After | | | |
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