**GALATIANS COMMUNITY HEALTH**

| **Patient Name:** |  | **DOB:** |  | **Chart#** |  |
| --- | --- | --- | --- | --- | --- |

**Gestational Diabetes / Food and Blood Sugar Log *\*Bring this form to EVERY visit for your provider to review.***

*Registro de diabetes gestacional / alimentos y azúcar en sangre \* Lleve este formulario a* ***CADA*** *visita para que su proveedor lo revise.*

| **DATE** | **Fasting Blood Sugar****(less than 95)** | **Breakfast** | **1hr after Breakfast - Blood Sugar****(less than 140)** | **Lunch** | **1hr after Lunch -** **Blood Sugar****(less than 140)** | **Dinner** | **1hr after Dinner -** **Blood Sugar****(less than 140)** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| *FECHA* | *azúcar en sangre en ayunas (menos de 95)* | *desayuno* | *1 hora después del desayuno - azúcar en sangre (menos de 140)* | *comida* | *1 hora después del almuerzo -**Glucemia**(menos de 140)* | *cena* | *1 hora después de la cena -**Glucemia**(menos de 140)* |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |