ROZIN Internal Medicine
Phone (770) 709-0900 Fax (770) 709-7444

Name	AM Insulin	N	R	
	PM Insulin	N	R	Lantus_________
	Oral Agent	Name	Dose	

Please fill in the date and your blood sugar value from your fingerstick reading for each day at the times marked with an "**X**". Fill in any comments (missed medications, over ate, etc).

Date	Before Breakfast	After Breakfast	Before Lunch	Before Dinner	After Dinner	Bedtime	Comments
	X	X		X			
	X		X	X			
	X			X			
	X			X	X		
	X			X		X	
	X	X		X			
	X		X	X			
	X			X			
	X			X	X		
	X			X		X	
	X	X		X			
	X		X	X			
	X			X			
	X			X	X		
	X			X		X	
	X	X		X			
	X		X	X			
	X			X			
	X			X	X		
	X			X		X	
	X	X		X			
	X		X	X			
	X			X			
	X			X	X		
	X			X		X	
	X	X		X			
	X		X	X			
	X			X			
	X			X	X		
	X			X		X	
	X	X		X			
	X		X	X			