

NAME: _____ BIRTHDATE: _____

PLEASE EMAIL ONE DAY PRIOR TO APPOINTMENT TO INFO@NUTRITIONASTHERAPY.NET

Dates: _____ to _____ Write down your blood sugar levels on the grey line right when you wake up fasting, 2 hours after eating Brkfst, 2 hours after eating Lunch, 2 hours after eating Dinner, and right before going to bed; also write down everything you eat, drink, and how much

FECHA: (DIA)							
TIME BREAKFAST	Fasting_____	Fasting_____	Fasting_____	Fasting_____	Fasting_____	Fasting_____	Fasting_____
	2 hours after eating Breakfast_____			2 hours after eating Breakfast_____			2 hours after eating Breakfast_____
TIME SNACK							
TIME LUNCHTIME							
		2 hours after eating Lunch_____			2 hours after eating Lunch_____		
TIME SNACK							
TIME DINNER							
			2 hours after eating Dinner_____			2 hours after eating Dinner_____	
TIME SNACK							

TIME EXERCISE							
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Before going to sleep

Before going to sleep

Before going to sleep

