Gestational Diabetes Daily Food Log

NorthShore University HealthSystem

Name: _____ DOB: ____ /____ / _____

Phone: _____ Physician/APN Name: _____

URINE KETONES (Goal: Neg or Trace): _____ Date: _____/____/_____

TIME	BLOOD SUGAR	FOOD ITEM/AMOUNT	GRAMS OF CARB	INSULIN DOSAGE
	Before Breakfast 1 Hour After Breakfast	Breakfast **TOTAL**		
		A.M. Snack **TOTAL**		
	1 Hour After Lunch	Lunch **TOTAL**		
		P.M. Snack **TOTAL**		
	1 Hour After Dinner	Dinner **TOTAL**		
		Bedtime Snack **TOTAL**		