

DATE: _____ TODAY'S GOAL: _____

Meal	Amount & Food	Calories	Protein	Carbs	Fat
B					
	Total Cups:				
L					
	Total Cups:				
D					
	Total Cups:				
Daily Totals					

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<p>Diabetic Patients Blood Sugar Log</p> <p>Morning (fasting):</p> <p>2 hrs after meal:</p> <p style="text-align: center;">/ /</p>	<p>Daily Nutrition Checklist</p> <p>Multivitamin <input type="checkbox"/> <input type="checkbox"/></p> <p>Calcium <input type="checkbox"/> <input type="checkbox"/></p> <p>Fish/Flax Oil <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>B Vitamin <input type="checkbox"/></p> <p>Protein Supplement <input type="checkbox"/> <input type="checkbox"/></p> <p>Fluid Intake:</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Exercise Log</p> <p>Activity</p> <p>Intensity</p> <p>Time</p>
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