Glucose Levels Monitoring Chart

Medical Institution Details

Name:

Address:

Phone Number:

Website:

Patient Details

Full Name:

Date of Birth:

Gender:

Patient ID:

Contact Number:

Email Address:

Referred by Dr./Physician:

Blood Glucose Monitoring

Date	Time	Reading (mg/dL)	Before/ After Meal	Meal Type (Breakfast/ Lunch/ Dinner)	Notes (e.g., exercise, stress, medication)

Medication and Dosage

Medication Name	Dosage	Frequency	Time of Day	Notes

Physical Activity

Date	Type of Activity	Duration (minutes)	Intensity	Time	Effect on Glucose (if known)

Dietary Intake (Sample)

Date	Meal Time	Food & Beverage Intake	Carbohydrate Content (if known)	Notes

Symptoms or Side Effects Noted

Recommendations & Physician's Notes

Next Appointment:

Physician's Signature: _____ Date: _____

Note: This chart is intended for tracking and management purposes. Always consult with a healthcare professional regarding any concerns or changes in treatment.