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[http://www.cdappsweetsuccess.org/Resources/
FreePatientEducationMaterial.aspx](http://www.cdappsweetsuccess.org/Resources/FreePatientEducationMaterial.aspx)

Revision based on: California Diabetes and Pregnancy Program Guidelines for Care.
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Adolescent Health Division

01/12 SS-2901



*Sweet
Success*

California Diabetes and Pregnancy Program

Record Book and Diary



GLUCOSE TESTS

2 Step Test

Date _____
 Test Done _____
 50 gram, 1 Hour Oral Glucose Challenge Test
 Weeks of pregnancy _____
 Test Result _____

Date _____
 Test Done _____
 100 gram, 3 Hour Oral Glucose Tolerance Test
 Weeks of pregnancy _____
 FBS _____ 1 Hr _____ 2 Hr _____ 3 Hr _____

1 Step Test

Date _____
 Test Done _____
 75 gram, 2 Hour Oral Glucose Tolerance Test
 Appointment Scheduled:
 Time _____ Place _____
 Results:
 Fasting _____ 2 Hr _____

Post partum Test

6 - 8 weeks Postpartum
 Date _____
 Test Done _____
 75 gram, 2 Hour Oral Glucose Tolerance Test
 Appointment Scheduled:
 Time _____ Place _____
 Results:
 Fasting _____ 2 Hr _____

You will be asked to check your blood sugar levels at home. Your diabetes team will teach you how to check and help you determine what your target blood sugar level should be. If you have any questions, be sure to ask someone on your team.

Your goals are:

Test _____ times a day. Fasting AM Before dinner
 After breakfast After dinner
 Before lunch Bedtime (9/10 pm)
 After lunch 2 am

Your blood sugar level should be between:

_____ and _____ **fasting** (before you eat anything),

_____ and _____, _____ hour(s) after beginning your meal.



WHERE TO CALL IF YOU NEED HELP WITH YOUR DIABETES

Office Appointment Desk _____

Number to use when
office is closed _____

Doctor _____

Nurse _____

Dietitian _____

Behavioral Medicine Specialist _____

Labor and Delivery Department _____

Other: _____

Other: _____

Dictionary

This diary may contain new words or words you don't understand. Most of these new words are medical terms. We have defined some of these words here for you. If you don't know what something means and it is not listed here, ask your diabetes team.

Behavioral Medicine Specialist - An expert on helping you understand and manage the stresses of your pregnancy. Also referred to as a Stress Counselor.

Fasting - Time between the last nighttime snack and breakfast, usually 8 or more hours. May drink water.

Fasting Blood Glucose Test - The lab test done to check blood sugar levels. Fasting means that this test is done before you eat anything.

Glucose - A form of sugar which is used by the body for energy and comes from food.

Insulin - A hormone made by the pancreas. Insulin lowers blood sugar and allows your body to use sugar for energy.

Nurse Educator - A registered nurse who is an expert in patient education and has special training in diabetes and pregnancy.

Registered Dietitian - An expert on food, your body's need for nutrients, and helping you set up a meal plan. Also referred to as a RD.

OFFICE VISIT NOTES

Date	Notes	Next Visit
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Pregnancy can be a time of many different feelings, changes, and stresses. Having diabetes during pregnancy often adds to the stress. Support from your health care team can help. Your Sweet Success team will help you with:

- ❖ eating well
- ❖ exercising
- ❖ checking your blood sugar
- ❖ managing your weight
- ❖ managing your stress

Please let us know how we can make this easier for you.



NOTES

NOTES

Some Things to Think About:

- ❖ The changes of pregnancy may make you feel worried, anxious or even angry. Talking about these feelings can help. Share them with a person you trust.
- ❖ Don't expect to be perfect; let us know when things are too hard for you to do.
- ❖ Stress can raise your blood sugar levels. When you feel worried, anxious, upset or nervous, please talk to someone on your Sweet Success team.
- ❖ Take time to relax. Try going for a walk, reading a book, listening to music, or visiting with a friend or neighbor.
- ❖ You might have questions for your health care team. You or a friend can write them down to ask at your next visit.

WHAT TO HYPOglycemia

If you take insulin or other medication to control your blood sugar, your blood sugars may go too low. This is called hypoglycemia.

Watch out for:

- ❖ Excessive sweating
- ❖ Headache
- ❖ Pounding of the heart
- ❖ Trembling/shakiness
- ❖ Sleepiness
- ❖ Numbness, tingling around mouth
- ❖ Hunger, weakness
- ❖ Feeling faint/dizzy
- ❖ Grouchiness/ crankiness
- ❖ Problems with your eyes
- ❖ Confusion

Causes:

- ❖ Too much insulin
- ❖ Exercise more than usual
- ❖ Sudden illness with vomiting
- ❖ Skipped meal or snack
- ❖ Late meal or snack
- ❖ Too little food

What to do:

Check your blood sugar!

If it is **less than 60 to 70**

1. Take 15 grams of carbohydrates. There are 15 grams of carbohydrates in:
 - 3 or 4 glucose tablets. Take the tablets with 1 cup water.
 - 1/2 cup juice or regular soda pop,
 - 1 cup milk.
2. Recheck your blood sugar after 15 minutes. Repeat the 15 grams of carbohydrate if your blood sugar is not above 60 to 70.
3. Follow with your next scheduled meal or snack.

If **above 60 to 70**, drink water and rest. Recheck your blood sugar after 15 minutes.

RECORDS

Write down everything you eat and drink. Tell us the time you ate, the amount you ate and how you cooked the food.

Date: _____	Date: _____	Date: _____
Breakfast	Time:	
Snack	Time:	
Lunch	Time:	
Snack	Time:	
Dinner	Time:	
Snack	Time:	

DAILY

Date Checked			
Fasting Urine Ketones			
Fasting Blood Sugar (BS)			
Insulin Amount/Time			
BS 1 hr after start of breakfast			
BS Before Lunch			
Insulin Amount/Time			
BS 1 hr after start of lunch			
BS Before Dinner			
Insulin Amount/Time			
BS 1-2 hrs after start of dinner			
BS 9 - 10 PM/Bedtime			
Insulin Amount/Time			
BS 2 AM (Optional)			
Exercise (type/when/how long)			
Kick Counts Times			
If you had or did any of the following, write it in the box:			
Illness:			
Overeating/Skipped Meal			
Problems/Concerns/Stressors:			

DO ABOUT HYPERglycemia

If you eat too much, are over stressed, don't take enough insulin, or have an infection or fever, your blood sugars may go too high. This is called hyperglycemia.

Watch out for:

- ❖ Increased thirst
- ❖ Increased urination
- ❖ Large amount of sugar and ketones in urine
- ❖ Weakness, abdominal and generalized pain
- ❖ Nausea and vomiting
- ❖ Loss of appetite

Causes:

- ❖ Too little insulin
- ❖ Overeating
- ❖ Infection, fever
- ❖ Emotional stress

What to do:

Check your blood sugar!

1. If it is **200 or higher**, check urine for ketones.
- 2. Call your diabetes team right away!**
3. Drink plenty of water.

KICK COUNTS

There are many tests that can be done to check on the health of your baby. One of the most important tests **you** can do is “kick counts”. Kick counts check your baby’s movements. Remember:

- ❖ Kick counts are a good way for you to check on your baby’s health.
- ❖ Kick counts are fun to do - just set aside time each day to notice your baby’s movements.
- ❖ Ask your health care provider about how to count your baby’s movements and when to start.
- ❖ Healthy babies move. Pay attention to how and when your baby usually moves. If this way changes, seems to be less or slows down, call your doctor right away or go to the Labor and Delivery Department at your hospital.



DON'T WAIT!

RECORDS

Write down everything you eat and drink. Tell us the time you ate, the amount you ate and how you cooked the food.

Date: _____	Date: _____	Date: _____
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Dinner Time:		
Snack Time:		

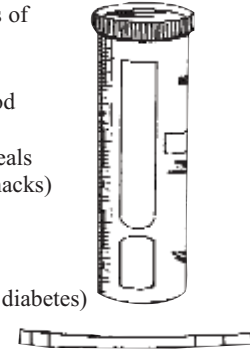
DAILY

Date Checked			
Fasting Urine Ketones			
Fasting Blood Sugar (BS)			
Insulin Amount/Time			
BS 1 hr after start of breakfast			
BS Before Lunch			
Insulin Amount/Time			
BS 1 hr after start of lunch			
BS Before Dinner			
Insulin Amount/Time			
BS 1-2 hrs after start of dinner			
BS 9 - 10 PM/Bedtime			
Insulin Amount/Time			
BS 2 AM (Optional)			
Exercise (type/when/how long)			
Kick Counts Times			
If you had or did any of the following, write it in the box:			
Illness:			
Overeating/Skipped Meal			
Problems/Concerns/Stressors:			

TESTING URINE FOR KETONES

You may be asked to test your urine for ketones. This is an easy test to do. It is done with a special plastic strip. Ketone tests should be negative. If you have ketones in your urine in more than trace amounts, call your diabetes team. The most common causes of ketones in the urine are:

- ❖ Not eating enough food
- ❖ Skipping snacks or meals (especially bedtime snacks)
- ❖ Illness
- ❖ (for those with type 1 diabetes) high blood sugars due to not enough insulin



If you had diabetes before you became pregnant, ketones are a more serious risk for you and your baby. Moderate to large amounts of ketones in your urine should be reported to your diabetes team right away. Always check your ketones if your blood sugar is over 200. If you are testing your ketones, write down all of your results in the “Records” section of this diary. It starts on page 25.

Preeclampsia

Preeclampsia (pre-e-clamp-sia) is a sickness that only happens during or right after pregnancy. It happens more in women with diabetes. During a normal pregnancy a woman's blood pressure goes down a little bit but in women with preeclampsia it goes up. Preeclampsia is a serious sickness because it can harm both mother and baby. This happens because blood cannot get to the baby or to your organs. Some signs of preeclampsia are:

- ❖ A severe headache.
- ❖ Changes in vision such as blurriness, spots, lines, or flashing lights.
- ❖ Severe or strong pain in any part of the body that does not go away.
- ❖ Sudden weight gain.
- ❖ Severe swelling of the face, fingers or feet.
- ❖ Baby moves less than normal.
- ❖ Any spotting of red blood from the vagina.

If you have any of these, call your doctor right now! If you are not sure but something does not seem right to you, it is always better to talk to your doctor or nurse. If you have any trouble reaching your health care provider you can also call or go to your hospital's Labor and Delivery Department for help.

When you come to get your diabetes checked, your team will also check your weight, blood pressure and an urine sample. We will ask you about these warning signs. Be sure you tell your team if you have **any** of these signs.

RECORDS

Write down everything you eat and drink. Tell us the time you ate, the amount you ate and how you cooked the food.

Date: _____	Date: _____	Date: _____
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Dinner Time:		
Snack Time:		

DAILY

Date Checked			
Fasting Urine Ketones			
Fasting Blood Sugar (BS)			
Insulin Amount/Time			
BS 1 hr after start of breakfast			
BS Before Lunch			
Insulin Amount/Time			
BS 1 hr after start of lunch			
BS Before Dinner			
Insulin Amount/Time			
BS 1-2 hrs after start of dinner			
BS 9 - 10 PM/Bedtime			
Insulin Amount/Time			
BS 2 AM (Optional)			
Exercise (type/when/how long)			
Kick Counts Times			
If you had or did any of the following, write it in the box:			
Illness:			
Overeating/Skipped Meal			
Problems/Concerns/Stressors:			

EXERCISE TIPS

Exercise is good for you. It will help you keep your blood sugar under control. Exercise can also help you control your weight, cope with stress, control your hunger and feel good about yourself.



- ❖ Talk to your doctor about the best exercise plan for you.
- ❖ Brisk walking before or after meals for 20 minutes or more will lower your blood sugar.
- ❖ Note the type and amount of exercise you did in your record book (see page 25).
- ❖ If you are taking insulin, talk to your diabetes team to develop a personal exercise plan for you.
 - Remember to eat your snack before you exercise and to carry a snack with you while you exercise.
 - Test your blood sugar before and after exercising.

PREGNANCY

Every pregnant woman has different weight gain needs. The amount of weight you should gain depends on how tall you are and how much you weighed BEFORE you got pregnant. For example, if you are (see the table below) before you got pregnant, you were “normal weight” and need to gain 25 to 35 pounds. Your CDAPP Sweet Success team will make recommendations for you. You can find charts to help track your weight gain on page:

- 11 if you were UNDER weight,
- 12 if you were NORMAL weight,
- 13 if you were OVER weight,
- 14 if you were OBESE

Your Height	Under Weight		Over Weight	Obese
4'7"	less than 80	80 to 107	108 to 128	more than 128
4'8"	less than 83	83 to 111	112 to 133	more than 133
4'9"	less than 86	86 to 115	116 to 138	more than 138
4'10"	less than 89	89 to 119	120 to 143	more than 143
4'11"	less than 92	92 to 123	124 to 148	more than 148
	less than 95		128 to 153	more than 153
5'1"	less than 98	98 to 132	133 to 158	more than 158
5'2"	less than 101	101 to 136	137 to 163	more than 163
5'3"	less than 105	105 to 140	141 to 169	more than 169
5'4"	less than 108	108 to 145	146 to 174	more than 174
5'5"	less than 111	111 to 149	150 to 179	more than 179
5'6"	less than 115	115 to 154	155 to 185	more than 185
5'7"	less than 118	118 to 159	160 to 191	more than 191
5'8"	less than 122	122 to 164	165 to 196	more than 196
5'9"	less than 125	125 to 168	169 to 202	more than 202
5'10"	less than 129	129 to 173	174 to 208	more than 208
5'11"	less than 133	133 to 178	179 to 214	more than 214
6'	less than 137	137 to 183	184 to 220	more than 220
6'1"	less than 140	140 to 189	190 to 227	more than 227
6'2"	less than 143	143 to 194	195 to 233	more than 233
6'3"	less than 148	149 to 199	200 to 239	more than 239

RECORDS

Write down everything you eat and drink. Tell us the time you ate, the amount you ate and how you cooked the food.

Date: _____	Date: _____	Date: _____
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Dinner Time:		
Snack Time:		

DAILY

Date Checked			
Fasting Urine Ketones			
Fasting Blood Sugar (BS)			
Insulin Amount/Time			
BS 1 hr after start of breakfast			
BS Before Lunch			
Insulin Amount/Time			
BS 1 hr after start of lunch			
BS Before Dinner			
Insulin Amount/Time			
BS 1-2 hrs after start of dinner			
BS 9 - 10 PM/Bedtime			
Insulin Amount/Time			
BS 2 AM (Optional)			
Exercise (type/when/how long)			
Kick Counts Times			
If you had or did any of the following, write it in the box:			
Illness:			
Overeating/Skipped Meal			
Problems/Concerns/Stressors:			

WEIGHT RECORD

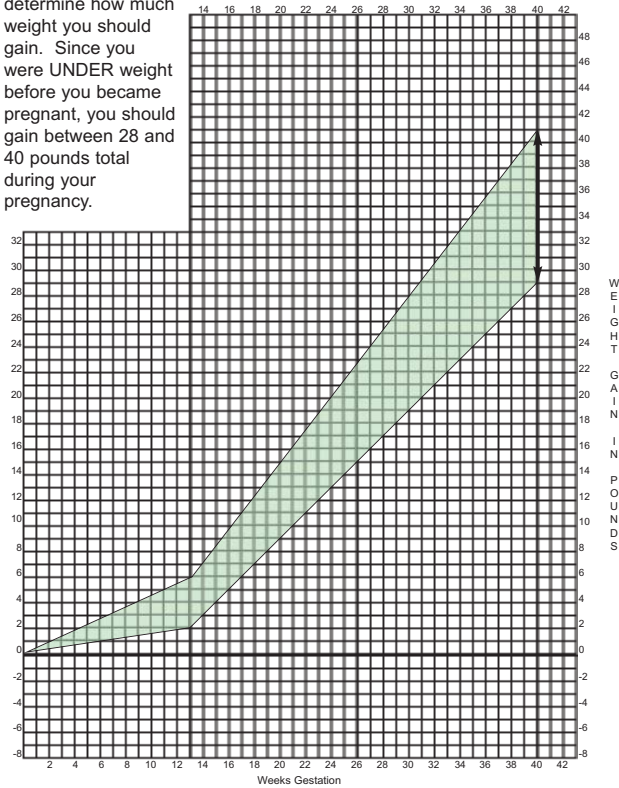
Date _____
 Height _____ Pre-pregnancy Weight _____

Your goal is to gain a total of _____ pounds.

Date	Weeks of Pregnancy	Weight	Pounds gained/lost
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Weight Gain Grid for UNDER Weight Pregnant Woman

Your diabetes team will use this graph to help you keep track of your weight gain. They will record your weight at each visit so you can see your progress. Your weight at the beginning of your pregnancy will determine how much weight you should gain. Since you were UNDER weight before you became pregnant, you should gain between 28 and 40 pounds total during your pregnancy.



RECORDS

Write down everything you eat and drink. Tell us the time you ate, the amount you ate and how you cooked the food.

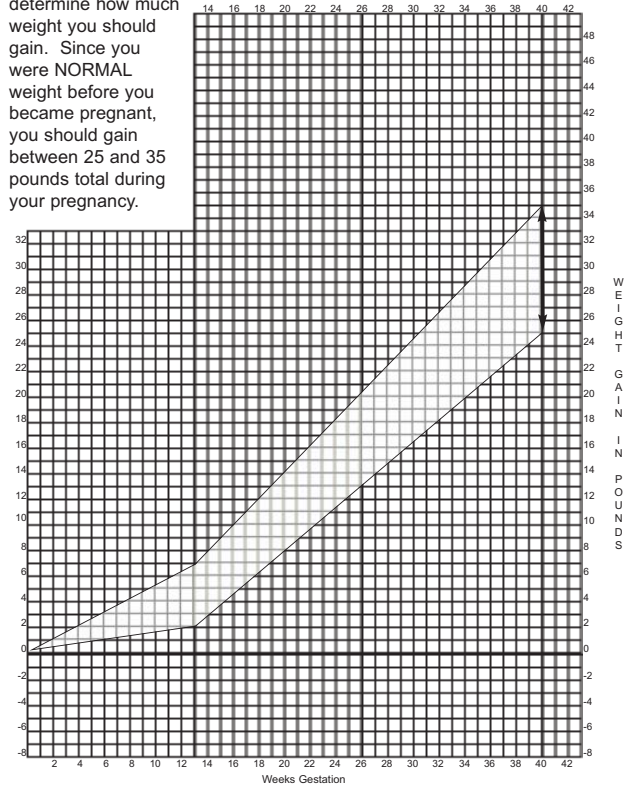
Date: _____	Date: _____	Date: _____
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Dinner Time:		
Snack Time:		

DAILY

Date Checked			
Fasting Urine Ketones			
Fasting Blood Sugar (BS)			
Insulin Amount/Time			
BS 1 hr after start of breakfast			
BS Before Lunch			
Insulin Amount/Time			
BS 1 hr after start of lunch			
BS Before Dinner			
Insulin Amount/Time			
BS 1-2 hrs after start of dinner			
BS 9 - 10 PM/Bedtime			
Insulin Amount/Time			
BS 2 AM (Optional)			
Exercise (type/when/how long)			
Kick Counts Times			
If you had or did any of the following, write it in the box:			
Illness:			
Overeating/Skipped Meal			
Problems/Concerns/Stressors:			

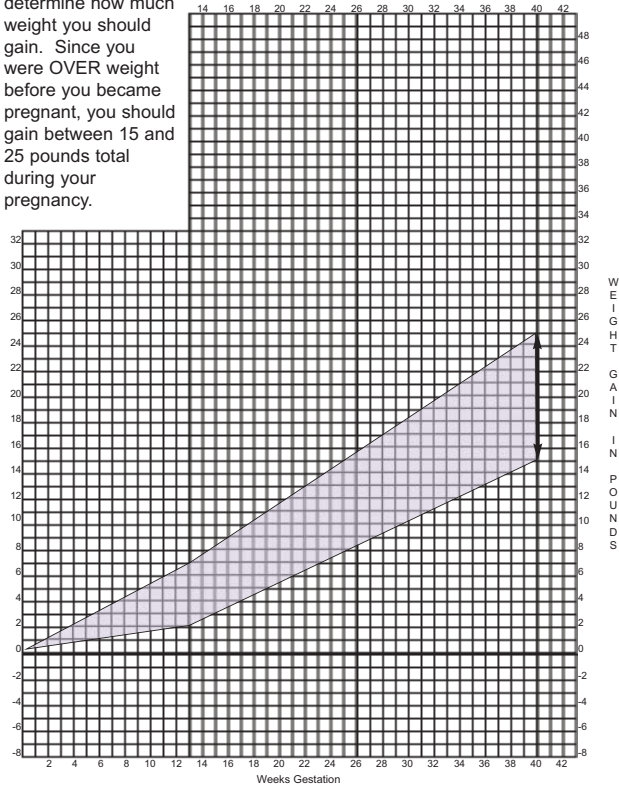
Weight Gain Grid for NORMAL Weight Pregnant Woman

Your diabetes team will use this graph to help you keep track of your weight gain. They will record your weight at each visit so you can see your progress. Your weight at the beginning of your pregnancy will determine how much weight you should gain. Since you were **NORMAL** weight before you became pregnant, you should gain between 25 and 35 pounds total during your pregnancy.



Weight Gain Grid for OVER Weight Pregnant Woman

Your diabetes team will use this graph to help you keep track of your weight gain. They will record your weight at each visit so you can see your progress. Your weight at the beginning of your pregnancy will determine how much weight you should gain. Since you were OVER weight before you became pregnant, you should gain between 15 and 25 pounds total during your pregnancy.



RECORDS

Write down everything you eat and drink. Tell us the time you ate, the amount you ate and how you cooked the food.

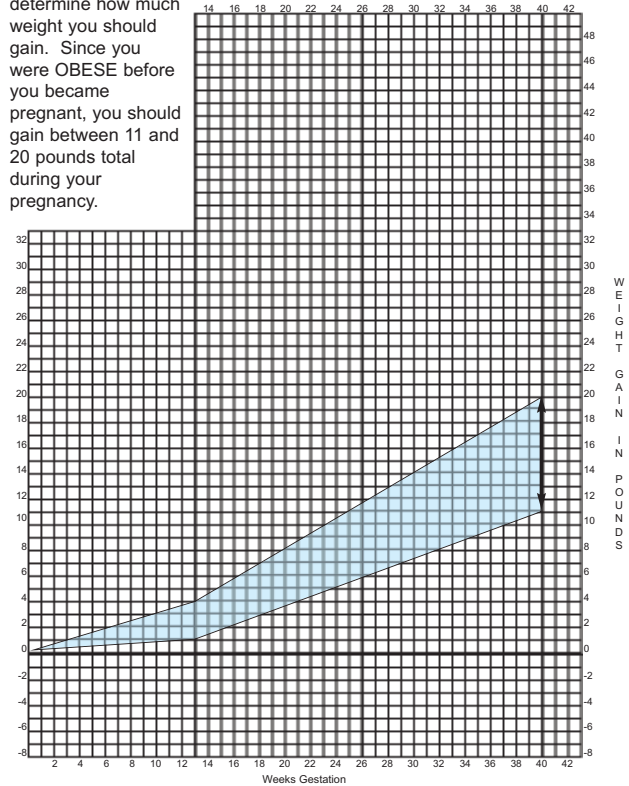
Date: _____	Date: _____	Date: _____	
Breakfast	Time:		
Snack	Time:		
Lunch	Time:		
Snack	Time:		
Dinner	Time:		
Snack	Time:		

DAILY

Date Checked			
Fasting Urine Ketones			
Fasting Blood Sugar (BS)			
Insulin Amount/Time			
BS 1 hr after start of breakfast			
BS Before Lunch			
Insulin Amount/Time			
BS 1 hr after start of lunch			
BS Before Dinner			
Insulin Amount/Time			
BS 1-2 hrs after start of dinner			
BS 9 - 10 PM/Bedtime			
Insulin Amount/Time			
BS 2 AM (Optional)			
Exercise (type/when/how long)			
Kick Counts Times			
If you had or did any of the following, write it in the box:			
Illness:			
Overeating/Skipped Meal			
Problems/Concerns/Stressors:			

Weight Gain Grid for OBESE Pregnant Woman

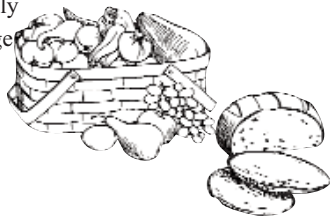
Your diabetes team will use this graph to help you keep track of your weight gain. They will record your weight at each visit so you can see your progress. Your weight at the beginning of your pregnancy will determine how much weight you should gain. Since you were OBESE before you became pregnant, you should gain between 11 and 20 pounds total during your pregnancy.



Your Food Plan

A food plan helps you decide when, what, and how to eat. Your health care team will help you develop a plan that works for you. Following your food plan is the key to controlling your blood sugar and keeping you and your baby healthy.

- ❖ Eat 3 small meals and 3 or more snacks every day.
- ❖ Follow the food plan given to you. Contact your RD if you would like to make changes.
- ❖ Avoid drinks that contain sugar like juice and regular soda.
- ❖ Wait at least 2 to 3 hours between all meals and snacks.
- ❖ Do not skip any meals or snacks. This will help you keep your blood sugars within a normal range.
- ❖ Plan ahead! If you will be away from home, pack your snacks and take them with you.
- ❖ Write down the time you start to eat your meals and snacks. See the Daily Food Record on page 25.
- ❖ Write down the amount you eat and drink.



RECORDS

Write down everything you eat and drink. Tell us the time you ate, the amount you ate and how you cooked the food.

Date: _____	Date: _____	Date: _____
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Dinner Time:		
Snack Time:		

DAILY

Date Checked			
Fasting Urine Ketones			
Fasting Blood Sugar (BS)			
Insulin Amount/Time			
BS 1 hr after start of breakfast			
BS Before Lunch			
Insulin Amount/Time			
BS 1 hr after start of lunch			
BS Before Dinner			
Insulin Amount/Time			
BS 1-2 hrs after start of dinner			
BS 9 - 10 PM/Bedtime			
Insulin Amount/Time			
BS 2 AM (Optional)			
Exercise (type/when/how long)			
Kick Counts Times			
If you had or did any of the following, write it in the box:			
Illness:			
Overeating/Skipped Meal			
Problems/Concerns/Stressors:			

Snack Ideas

Deciding what to eat can be difficult. Here are a few snack ideas. Each one has about 30 grams of carbohydrates.

1 cup plain yogurt or aspartame sweetened yogurt
3 tablespoons of Grape Nuts™ cereal



14 Ritz™ crackers
Broth



1/2 large bagel
Peanut butter or cheese



2 rice cakes
1 cup milk



2 small corn tortillas
1 ounce low fat cheese
salsa



1 cup soup (read labels for carbohydrate content)
6 saltine crackers



1 small apple
7 Ritz™ crackers
1 string cheese

MY FOOD PLAN

Time	Meal Plan # of Choices	Food Groups
Meal	_____	Starch
	_____	Milk
	_____	Fruit
	_____	Vegetables
	_____	Protein
	_____	Fat
Snack	_____	_____
	_____	_____
	_____	_____
Meal	_____	Starch
	_____	Milk
	_____	Fruit
	_____	Vegetables
	_____	Protein
	_____	Fat
Snack	_____	_____
	_____	_____
	_____	_____
Meal	_____	Starch
	_____	Milk
	_____	Fruit
	_____	Vegetables
	_____	Protein
	_____	Fat
Snack	_____	_____
	_____	_____
	_____	_____

RECORDS

Write down everything you eat and drink. Tell us the time you ate, the amount you ate and how you cooked the food.

Date: _____	Date: _____	Date: _____
Breakfast	Time: _____	
Snack	Time: _____	
Lunch	Time: _____	
Snack	Time: _____	
Dinner	Time: _____	
Snack	Time: _____	

DAILY

Date Checked				
Fasting Urine Ketones				
Fasting Blood Sugar (BS)				
Insulin Amount/Time				
BS 1 hr after start of breakfast				
BS Before Lunch				
Insulin Amount/Time				
BS 1 hr after start of lunch				
BS Before Dinner				
Insulin Amount/Time				
BS 1-2 hrs after start of dinner				
BS 9 - 10 PM/Bedtime				
Insulin Amount/Time				
BS 2 AM (Optional)				
Exercise (type/when/how long)				
Kick Counts Times				
If you had or did any of the following, write it in the box:				
Illness:				
Overeating/Skipped Meal				
Problems/Concerns/Stressors:				

Date _____

Dietitian _____ Phone _____

Calories _____ CHO _____ Protein _____ Fat _____

Menu Ideas

MY FOOD PLAN

Time	Meal Plan # of Choices	Food Groups
Meal	_____	Starch
	_____	Milk
	_____	Fruit
	_____	Vegetables
	_____	Protein
	_____	Fat
Snack	_____	_____
	_____	_____
	_____	_____
Meal	_____	Starch
	_____	Milk
	_____	Fruit
	_____	Vegetables
	_____	Protein
	_____	Fat
Snack	_____	_____
	_____	_____
	_____	_____
Meal	_____	Starch
	_____	Milk
	_____	Fruit
	_____	Vegetables
	_____	Protein
	_____	Fat
Snack	_____	_____
	_____	_____
	_____	_____

RECORDS

Write down everything you eat and drink. Tell us the time you ate, the amount you ate and how you cooked the food.

Date: _____	Date: _____	Date: _____
Breakfast	Time: _____	
Snack	Time: _____	
Lunch	Time: _____	
Snack	Time: _____	
Dinner	Time: _____	
Snack	Time: _____	

DAILY

Date Checked			
Fasting Urine Ketones			
Fasting Blood Sugar (BS)			
Insulin Amount/Time			
BS 1 hr after start of breakfast			
BS Before Lunch			
Insulin Amount/Time			
BS 1 hr after start of lunch			
BS Before Dinner			
Insulin Amount/Time			
BS 1-2 hrs after start of dinner			
BS 9 - 10 PM/Bedtime			
Insulin Amount/Time			
BS 2 AM (Optional)			
Exercise (type/when/how long)			
Kick Counts Times			
If you had or did any of the following, write it in the box:			
Illness:			
Overeating/Skipped Meal			
Problems/Concerns/Stressors:			

Date _____
Dietitian _____ Phone _____
Calories _____ CHO _____ Protein _____ Fat _____

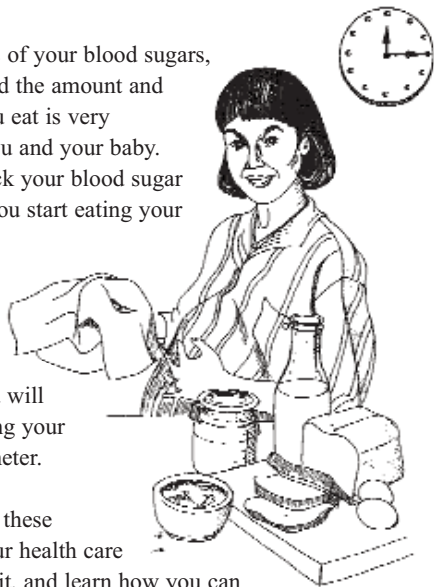
Menu Ideas

Keeping records of your blood sugars, urine ketone, and the amount and kind of food you eat is very important for you and your baby. You should check your blood sugar one hour after you start eating your meal.

Bring this record book with you to every visit. You will also need to bring your blood glucose meter.

You will review these records with your health care team at each visit, and learn how you can keep your blood sugars at normal levels for pregnancy.

We know filling out this record book requires hard work, but it is worth the effort. You are doing the best for you and your baby.



RECORDS

Write down everything you eat and drink. Tell us the time you ate, the amount you ate and how you cooked the food.

Date: _____	Date: _____	Date: _____
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Dinner Time:		
Snack Time:		

DAILY

Date Checked			
Fasting Urine Ketones			
Fasting Blood Sugar (BS)			
Insulin Amount/Time			
BS 1 hr after start of breakfast			
BS Before Lunch			
Insulin Amount/Time			
BS 1 hr after start of lunch			
BS Before Dinner			
Insulin Amount/Time			
BS 1-2 hrs after start of dinner			
BS 9 - 10 PM/Bedtime			
Insulin Amount/Time			
BS 2 AM (Optional)			
Exercise (type/when/how long)			
Kick Counts Times			
If you had or did any of the following, write it in the box:			
Illness:			
Overeating/Skipped Meal			
Problems/Concerns/Stressors:			

SAMPLE Food Record

This is an example of how to fill out your daily food records. If you have any questions, ask your diabetes team.

Date: <u>6/2</u>	Date: <u>6/3</u>	Date: <u>6/4</u>
Breakfast Time: 8am	8 am	7:30 am
Coffee shop: 2 eggs	1/2 cup oatmeal	2 slices toast
2 sausage links	1/2 cup skim milk	1 tblspn peanut butter
hash brown potatoes	1 soft boiled egg	coffee with cream
coffee with cream	coffee with cream	
Snack Time: 10 am	10 am	9:30 am
1/4 cantaloupe	12 cherries	1 small orange
	1 tblspn peanut butter	1oz mozzarella cheese
	6 saltines	2 bread sticks
Lunch Time: 12pm	12 noon	12 noon
tomato and cheese	1 cup nonfat milk	2 beef tacos with
sandwich	1 cup macaroni/cheese	lettuce, cheese &
1 tspoon mayonnaise	garden salad with	tomato
8 ounces nonfat milk	lite ranch dressing	diet coke
celery & carrot sticks		
Snack Time: 3 pm	3 pm	2:30 pm
1/4 cup cottage cheese	1 small apple	1/2 banana
1 small peach	1 ounce cheese	1 cp sugar free yogurt
Dinner Time: 6 pm	6 pm	5:30 pm
3 ounce baked chicken	1 slice garlic bread	1 dinner roll
medium baked potato	3 ounce lean beef	3 ounce fish
1/2 cup corn	1 cup spaghetti	2/3 cup rice
green salad	with tomato sauce	1 cup broccoli
1 cup nonfat milk	1 cup zucchini	1 tspoon margarine
salad dressing	1 cup nonfat milk	1 cup nonfat milk
Snack Time: 8:30	8:30 pm	8 pm
1 cp sugar free yogurt	1 cup watermelon	12 peanuts
1 cup raspberries	1/4 cup cottage cheese	1 cup nonfat milk

DAILY

Date Checked			
Fasting Urine Ketones			
Fasting Blood Sugar (BS)			
Insulin Amount/Time			
BS 1 hr after start of breakfast			
BS Before Lunch			
Insulin Amount/Time			
BS 1 hr after start of lunch			
BS Before Dinner			
Insulin Amount/Time			
BS 1-2 hrs after start of dinner			
BS 9 - 10 PM/Bedtime			
Insulin Amount/Time			
BS 2 AM (Optional)			
Exercise (type/when/how long)			
Kick Counts Times			
If you had or did any of the following, write it in the box:			
Illness:			
Overeating/Skipped Meal			
Problems/Concerns/Stressors:			

RECORDS

Write down everything you eat and drink. Tell us the time you ate, the amount you ate and how you cooked the food.

Date: _____	Date: _____	Date: _____
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Dinner Time:		
Snack Time:		