



# Record-Keeping Charts

In this appendix, we have provided some useful charts for you so you can record information that's important to manage your diabetes. Use these charts to keep track of the information not only for yourself, but also for your diabetes care team to review with them as needed. Feel free to make multiple copies of these for daily use, or go to [idiotsguides.com/type2diabetes](http://idiotsguides.com/type2diabetes) to print them out.

# Diabetes Care Measures

The American Diabetes Association recommends certain treatment goals for good diabetes management, the measures of which are listed here. Use this chart at your doctor visits to track your diabetes measures.

| <b>Tests (How Often)</b>                      | <b>ADA Goal</b> | <b>My Goal</b> | <b>Date of Visit</b> |  |  |
|---|-----------------|----------------|----------------------|--|--|
| A1C (Every 3-6 Months)                        | Below 7%        |                |                      |  |  |
|   |                 |                | <b>Results</b>       |  |  |
| Blood Pressure (Each Visit)                   | Below 140/90    |                |                      |  |  |
|   |                 |                |                      |  |  |
| Cholesterol (Yearly)                          | Total           | Below 200      |                      |  |  |
|   | LDL             | Below 100      |                      |  |  |
|   | HDL             | > 40 (Male)    |                      |  |  |
|   |                 | > 50 (Female)  |                      |  |  |
| Triglycerides (Yearly)                        | Below 150       |                |                      |  |  |
| Foot Exam (Each Visit)                        |                 |                |                      |  |  |
| Urine Test for Protein (Yearly)               |                 |                |                      |  |  |
| Blood Test for Kidney Function (GFR) (Yearly) |                 |                |                      |  |  |
| Dilated Eye Exam (Yearly)                     |                 |                |                      |  |  |
| Dental Exam (Every 6 Months)                  |                 |                |                      |  |  |
| Flu Shot (Yearly)                             |                 |                |                      |  |  |
| Weight (Each Visit)                           |                 |                |                      |  |  |

| Check off ( ) the following when reviewed with your medical provider. |                                  |  |  |
|---|----------------------------------|--|--|
| Blood Glucose (My Targets)  | Before Meals:<br>80 to 130 mg/dL |  |  |
|   | Bedtime:<br>100 to 140 mg/dL     |  |  |
| Eating Well   |                                  |  |  |
| Exercise  |                                  |  |  |
| Blood Sugar Testing   |                                  |  |  |
| Blood Glucose Records   |                                  |  |  |
| High and Low Blood Sugar Frequency                                    |                                  |  |  |
| Medicine  |                                  |  |  |
| Daily Aspirin Use   |                                  |  |  |
| Foot Care   |                                  |  |  |
| Sick Day Care   |                                  |  |  |
| Stress Management   |                                  |  |  |
| Tobacco/Alcohol Use   |                                  |  |  |

Date of Pneumonia Shot: \_\_\_\_\_

Completed Diabetes Self-Management Education Program: \_\_\_\_\_

# Food and Blood Glucose Record

Use the following food and blood glucose record to keep track of your blood glucose results and food intake to help you identify if any changes are needed in your meal plan. You don't have to test your blood glucose before and after every meal, depending on what you are trying to find out. Talk with your medical provider about how often you should test your blood glucose.

| Date | Before Time | After Time | Breakfast | After Time | Before Time | Lunch  | After Time | Before Time | After Time | Dinner | After Time | Bedtime |
|------|-------------|------------|-----------|------------|-------------|--------|------------|-------------|------------|--------|------------|---------|
|      | Result      | Result     | Result    | Result     | Result      | Result | Result     | Result      | Result     | Result | Result     | Result  |
|      | ---         | ---        |           | ---        | ---         |        | ---        | ---         | ---        |        | ---        |         |
|      | ---         | ---        |           | ---        | ---         |        | ---        | ---         | ---        |        | ---        |         |
|      | ---         | ---        |           | ---        | ---         |        | ---        | ---         | ---        |        | ---        |         |

Record-Keeping Charts

| Date | Before Time<br>----<br>Result | Breakfast | After Time<br>----<br>Result | Before Time<br>----<br>Result | Lunch | After Time<br>----<br>Result | Before Time<br>----<br>Result | Dinner | After Time<br>----<br>Result | Bedtime |
|------|-------------------------------|-----------|------------------------------|-------------------------------|-------|------------------------------|-------------------------------|--------|------------------------------|---------|
|      | ---                           |           | ---                          | ---                           |       | ---                          | ---                           |        | ---                          |         |
|      | ---                           |           | ---                          | ---                           |       | ---                          | ---                           |        | ---                          |         |

# Blood Glucose Record for Insulin Users

Use the following record to record the time your insulin dose was taken, along with what type and how many units in the section to the left. To the right, list the time you took your blood glucose and the result in the appropriate column.

| Date |      | Insulin |      |         |       | Blood Glucose Results |                      |               |                      |               |                      | Notes         |         |       |  |  |
|------|------|---------|------|---------|-------|-----------------------|----------------------|---------------|----------------------|---------------|----------------------|---------------|---------|-------|--|--|
| Type | Dose | Morning | Noon | Evening | Night | Test                  | Breakfast            |               | Lunch                |               | Dinner               |               | Bedtime | Night |  |  |
|      |      |         |      |         |       |                       | Before 2 Hours After | 2 Hours After | Before 2 Hours After | 2 Hours After | Before 2 Hours After | 2 Hours After |         |       |  |  |
|      |      |         |      |         |       | Time of Test          |                      |               |                      |               |                      |               |         |       |  |  |
|      |      |         |      |         |       | Blood Glucose         |                      |               |                      |               |                      |               |         |       |  |  |
|      |      |         |      |         |       |                       |                      |               |                      |               |                      |               |         |       |  |  |
|      |      |         |      |         |       | Time of Test          |                      |               |                      |               |                      |               |         |       |  |  |
|      |      |         |      |         |       | Blood Glucose         |                      |               |                      |               |                      |               |         |       |  |  |

Record-Keeping Charts

| Date | Insulin    |  |  | Blood Glucose Results |               |  |  |
|------|------------|--|--|-----------------------|---------------|--|--|
|      | Time Taken |  |  | Time of Test          | Blood Glucose |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |
|      |            |  |  |                       |               |  |  |

## Food Record Rating Hunger and Fullness

If you've become out of touch with your physical feelings of hunger and fullness, you can use this one-day record to improve your awareness by rating your hunger and fullness level before and after eating. Use the column to the right to record any observations about what type of foods you chose, size of portions, or emotions surrounding the eating episode. Copy this for a week's worth of records.

| Time | Hunger Level Before Eating (0 to 5) | Foods | Hunger Level Before Eating (0 to 5) | Observations About Food Choices, Portions Eaten, and Emotions (Like Stress or Boredom) |
|------|-------------------------------------|-------|-------------------------------------|--|
|      |                                     |       |                                     |  |
|      |                                     |       |                                     |  |
|      |                                     |       |                                     |  |
|      |                                     |       |                                     |  |
|      |                                     |       |                                     |  |
|      |                                     |       |                                     |  |

*Hunger level key: 0 = Not hungry at all, 5 = Uncomfortably full.*



## Physical Activity Tracker

The following chart will help you track your weekly physical activity to ensure you're staying on the right track.

WEEK BEGINNING: \_\_\_/\_\_\_/\_\_\_ Weekly Activity Goal: \_\_\_\_\_

Weekly Activity Plan:

---

---

---

---

MONDAY:

Activity Type:

- Walking       Jogging       Treadmill       Swimming  
 Biking       Exercise Class       Other \_\_\_\_\_

Aerobic Activity (check one box for each 10 minutes of aerobic activity completed):

Intensity:       Easy       Medium       Hard

Resistance or Strength Training Activity:

- Weight Machine       Free Weights       Resistance Bands  
 Body Weight Resistance (Push-Ups, Pull-Ups, etc.)       Other \_\_\_\_\_

Notes:

---

---

---

---

Record-Keeping Charts

---

TUESDAY:

Activity Type:

- Walking       Jogging       Treadmill       Swimming  
 Biking       Exercise Class       Other \_\_\_\_\_

Aerobic Activity (check one box for each 10 minutes of aerobic activity completed):

Intensity:       Easy       Medium       Hard

Resistance or Strength Training Activity:

- Weight Machine       Free Weights       Resistance Bands  
 Body Weight Resistance (Push-Ups, Pull-Ups, etc.)       Other \_\_\_\_\_

Notes:

---

---

---

---

WEDNESDAY:

Activity Type:

- Walking       Jogging       Treadmill       Swimming  
 Biking       Exercise Class       Other \_\_\_\_\_

Aerobic Activity (check one box for each 10 minutes of aerobic activity completed):

Intensity:       Easy       Medium       Hard

Resistance or Strength Training Activity:

- Weight Machine       Free Weights       Resistance Bands  
 Body Weight Resistance (Push-Ups, Pull-Ups, etc.)       Other \_\_\_\_\_

Notes:

---

---

---

---

Record-Keeping Charts

---

THURSDAY:

Activity Type:

- Walking       Jogging       Treadmill       Swimming  
 Biking       Exercise Class       Other \_\_\_\_\_

Aerobic Activity (check one box for each 10 minutes of aerobic activity completed):

Intensity:       Easy       Medium       Hard

Resistance or Strength Training Activity:

- Weight Machine       Free Weights       Resistance Bands  
 Body Weight Resistance (Push-Ups, Pull-Ups, etc.)       Other \_\_\_\_\_

Notes:

---

---

---

---

FRIDAY:

Activity Type:

- Walking       Jogging       Treadmill       Swimming  
 Biking       Exercise Class       Other \_\_\_\_\_

Aerobic Activity (check one box for each 10 minutes of aerobic activity completed):

Intensity:       Easy       Medium       Hard

Resistance or Strength Training Activity:

- Weight Machine       Free Weights       Resistance Bands  
 Body Weight Resistance (Push-Ups, Pull-Ups, etc.)       Other \_\_\_\_\_

Notes:

---

---

---

---

Record-Keeping Charts

---

SATURDAY:

Activity Type:

- Walking       Jogging       Treadmill       Swimming  
 Biking       Exercise Class       Other \_\_\_\_\_

Aerobic Activity (check one box for each 10 minutes of aerobic activity completed):

Intensity:       Easy       Medium       Hard

Resistance or Strength Training Activity:

- Weight Machine       Free Weights       Resistance Bands  
 Body Weight Resistance (Push-Ups, Pull-Ups, etc.)       Other \_\_\_\_\_

Notes:

---

---

---

---

Record-Keeping Charts

---

SUNDAY:

Activity Type:

- Walking       Jogging       Treadmill       Swimming  
 Biking       Exercise Class       Other \_\_\_\_\_

Aerobic Activity (check one box for each 10 minutes of aerobic activity completed):

Intensity:       Easy       Medium       Hard

Resistance or Strength Training Activity:

- Weight Machine       Free Weights       Resistance Bands  
 Body Weight Resistance (Push-Ups, Pull-Ups, etc.)       Other \_\_\_\_\_

Notes:

---

---

---

---

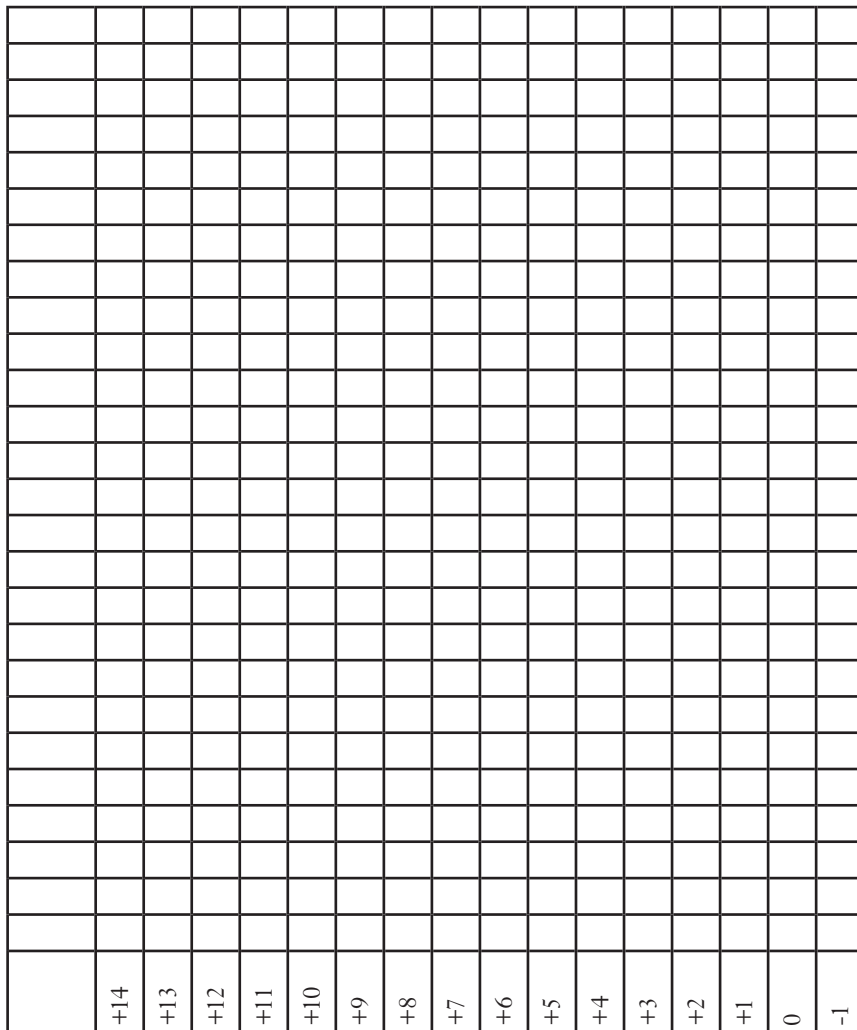
# Your Weight Record

Use the columns to the left to record your weekly weight, including the date and a running total of pounds lost each week. Use the graph on the right to record changes in your weight. Your starting weight should be graphed at 0 (toward the bottom of the page). Each square across represents one week, and each row represents 1 pound (either gained or lost starting from 0 on the graph).

Name: \_\_\_\_\_

Target Weight: \_\_\_\_\_

| Week | Date | Weight | Pounds Lost |
|------|------|--------|-------------|
| 1    |      |        |             |
| 2    |      |        |             |
| 3    |      |        |             |
| 4    |      |        |             |
| 5    |      |        |             |
| 6    |      |        |             |
| 7    |      |        |             |
| 8    |      |        |             |
| 9    |      |        |             |
| 10   |      |        |             |
| 11   |      |        |             |
| 12   |      |        |             |
| 13   |      |        |             |
| 14   |      |        |             |
| 15   |      |        |             |
| 16   |      |        |             |





## Your Diabetes Care Team

Use this chart to list the contact information for each of the members of your diabetes care team.

| Health-Care Provider | Location | Phone Number | Notes |
|----------------------|----------|--------------|-------|
|                      |          |              |       |
|                      |          |              |       |
|                      |          |              |       |
|                      |          |              |       |
|                      |          |              |       |
|                      |          |              |       |
|                      |          |              |       |



## Your Medication List

The following chart will help you list all of your medications in one place. Take this list with you to appointments with your diabetes care team. Keeping your providers informed about what medications you're taking will help you avoid duplicate medications and minimize the risk for adverse reactions.

Name: \_\_\_\_\_ Medication Allergies: \_\_\_\_\_

| Medication (Brand Name or Generic Name) | Dose (How Much You Take) | How Often You Take It | Reason for Taking the Medication | Who Prescribed the Medication |
|---|--------------------------|-----------------------|----------------------------------|-------------------------------|
|   |                          |                       |                                  |                               |
|   |                          |                       |                                  |                               |
|   |                          |                       |                                  |                               |
|   |                          |                       |                                  |                               |
|   |                          |                       |                                  |                               |
|   |                          |                       |                                  |                               |

## SMART Goal-Setting Worksheet

Use this worksheet to develop SMART goals to better manage your diabetes. It's a good idea to choose no more than two goals at the same time.

### *What Is a SMART Goal?*

**Specific:** Specifically state what you want to accomplish.

**Measurable:** How much or how often?

**Action-oriented:** What steps you will take to achieve your goal.

**Realistic:** It should be a bit of a challenge but not too difficult.

**Timely:** When will it happen?

### *Sample Goal Statement:*

“I want to improve my blood glucose control to feel better and have more energy.”

### *Sample Action Steps Using SMART Goal Setting:*

Activity goal: “I will walk at the park for 30 minutes, in the morning before work, on Monday, Wednesday, and Friday this week.”

Meal-planning goal: “I will choose fruit for a snack in the afternoon instead of chips or candy three days this week.”

## Record-Keeping Charts

---

Now put your plan into action. What is your goal? List why you chose that goal.

---

---

---

---

What steps will you take to reach your goal? Make them SMART.

---

---

---

---