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DIABETIC FORM

Patient: _____

Owner: _____

Date: _____

Doctor: _____

Type of Insulin: _____

Amount of Insulin: _____

Time Insulin Given: _____ AM _____ PM

Was Insulin Given Today? Yes/No (please circle one)

Type of Food _____

Amount Fed _____

Times Fed: _____ AM _____ PM

How is Appetite? Good / Fair / Poor (please circle one)

Snacks (type) _____ Given When _____

Amount of Exercise: _____

Times Exercised: _____

Recent Keto-Diastic Results: _____

Any Recent Vomiting or Diarrhea? Yes/No (please circle one)

If yes, when? _____