Gestational Diabetes Diet Chart

Name: _____ Age: _____ Height: _____ Weight: _____

Recommended blood sugar level range: _____

Day 1	**Food items**	**Portion**	**Notes (e.g. blood sugar level)**
Breakfast			
Morning snack			
Lunch			
Afternoon snack			
Dinner			
Day 2	**Food items**	**Portion**	**Notes (e.g. blood sugar level)**
Breakfast			
Morning snack			
Lunch			
Afternoon snack			
Dinner			

Day 3	Food items	Portion	Notes (e.g. blood sugar level)
Breakfast			
Morning snack			
Lunch			
Afternoon snack			
Dinner			
Day 4	**Food items**	**Portion**	**Notes (e.g. blood sugar level)**
Breakfast			
Morning snack			
Lunch			
Afternoon snack			
Dinner			

Day 5	Food items	Portion	Notes (e.g. blood sugar level)
Breakfast			
Morning snack			
Lunch			
Afternoon snack			
Dinner			
Day 6	**Food items**	**Portion**	**Notes (e.g. blood sugar level)**
Breakfast			
Morning snack			
Lunch			
Afternoon snack			
Dinner			

Day 7	Food items	Portion	Notes (e.g. blood sugar level)
Breakfast			
Morning snack			
Lunch			
Afternoon snack			
Dinner			

Additional notes

Healthcare professional’s information	
Name:	License number:
Signature:	Contact information: