Gestational Diabetes

What You Need to Know During Pregnancy

A Helpful Guide for Moms-to-Be

For educational purposes only. This booklet is not a substitute for medical advice. Always follow your healthcare provider's recommendations.

Prepared by: Dr. Tambi, OB/GYN

This booklet is intended for educational purposes only. It does not replace medical advice, diagnosis, or treatment. Always follow the guidance of your healthcare provider. If you have questions or concerns about your pregnancy or your health, please consult your doctor or midwife.

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Welcome to Your Pregnancy Journey

Congratulations on your pregnancy! This is a special time in your life, filled with excitement, changes, and new experiences. Along the way, you may have been told that you have *gestational diabetes.*

Hearing those words can feel overwhelming at first. But please know this: you are not alone, and with the right care, most women with gestational diabetes go on to have healthy pregnancies and healthy babies.

This booklet was created to help you:

- Understand what gestational diabetes is and why it happens
- Learn how it may affect you and your baby
- Discover simple, practical ways to keep your blood sugar in a healthy range
- Feel supported and confident as you care for yourself and your baby

Take this one step at a time. By following your care plan and making small, steady changes, you can protect your health and your baby's health. Along the way, you'll also learn many useful skills—about nutrition, exercise, and self-care—that can benefit you not just in pregnancy, but throughout your life.

This booklet is designed to guide you, alongside the care and recommendations of your healthcare provider.

Understanding Gestational Diabetes

Gestational diabetes, often called ***GDM***, is a type of diabetes that happens only during pregnancy. It means your body is having trouble keeping blood sugar (glucose) levels in the normal range.
Unlike other forms of diabetes, gestational diabetes usually:

- Develops in the second half of pregnancy
- Goes away after your baby is born
- Can be managed with healthy lifestyle changes and, if needed, medication

Why does this happen?

During pregnancy, your placenta produces several hormones that help your baby grow and develop. One important hormone is called ***human placental lactogen (hPL).***

- **What hPL does**: It changes how your body uses energy. It makes your cells less sensitive to insulin, so more glucose stays in your bloodstream. This ensures your baby has a steady supply of glucose and nutrients to grow.
- **When it peaks**: hPL levels rise as your pregnancy progresses and are highest in the third trimester, when your baby's growth needs are greatest.
- **How it affects you**: While this process is normal, sometimes your body cannot make enough extra insulin to overcome the resistance caused by hPL and other pregnancy hormones. When this happens, blood glucose levels stay too high — and this leads to gestational diabetes.

Why is it important to treat gestational diabetes?

Most women with gestational diabetes have healthy pregnancies and healthy babies — **as long as blood glucose levels are well managed**. But if it is not controlled, higher blood glucose levels can create problems for both you and your baby.

For You (Mom):

- ***High blood pressure (preeclampsia)***: GDM increases the risk of pregnancy-related high blood pressure, which can be dangerous for you and your baby.
- ***Cesarean birth (C-section)***: Babies who grow very large may be harder to deliver vaginally, increasing the chance of needing surgery.
- ***Future diabetes***: Women with GDM have a higher chance of developing type 2 diabetes later in life.

For Your Baby:

- ***Larger size (macrosomia).*** Extra glucose from mom crosses the placenta; baby makes more insulin, which drives growth and fat storage. Bigger babies raise the chance of shoulder dystocia, birth injury, and C-section.
- ***Low blood sugar after birth (neonatal hypoglycemia).*** After delivery the maternal glucose supply stops, but baby's insulin can still be high for a while—so blood sugar can drop and needs monitoring and early feeding/treatment if needed.
- ***Breathing problems.*** Babies of mothers with diabetes have a higher risk of respiratory distress right after birth; good glucose control lowers risk.
- ***Future risk.*** Children exposed to high glucose in pregnancy have a higher risk of obesity and type 2 diabetes later in life.

When you'll be tested

Most pregnant women are screened between 24 and 28 weeks of pregnancy. If you have risk factors (e.g., prior GDM, delivered a large baby in the past, prediabetes, obesity, hypertension, PCOS, insulin resistance), you may be tested earlier in pregnancy.

Two accepted ways to test

Clinics use one of two evidence-based approaches. Your care team will choose the one they use routinely.

Option A – Two-step approach (common in the U.S.)

1. ***Screening test (no fasting)***: You drink a 50-g glucose drink; your blood is drawn 1 hour later.
    - If your result is below your clinic's cutoff (typically ≤130–140 mg/dL, depending on the lab), you're done.
    - If it's at or above the cutoff, you'll have the diagnostic test.
2. ***Diagnostic test (fasting 8–14 hours; water OK)***: A fasting blood sample is drawn, you drink a 100-g glucose drink, and blood samples are drawn at 1, 2, and 3 hours afterward.
    - Diagnosis: Gestational diabetes is diagnosed when two or more results meet or exceed the clinic's thresholds.

Option B – One-step approach

Come fasting for a 75-g, 2-hour OGTT with blood draws at fasting, 1 hour, and 2 hours.

- Diagnosis: GDM is diagnosed if any of the values meets/exceeds the thresholds.

Both options A and B are supported by major guidelines. The one-step approach diagnoses more women with GDM but does not improve key maternal or neonatal outcomes, versus the two-step approach, so either can be used.

oGTT = oral Glucose Tolerance Test.
It's a lab test that shows how your body handles a measured dose of sugar. You drink a glucose drink, then have timed blood draws to see how quickly your body moves sugar out of the bloodstream. It's the standard test to diagnose gestational diabetes (GDM) in pregnancy (and is also used outside pregnancy to diagnose diabetes/prediabetes).

Prep tips:

- Fast 8–14 hours if your clinic tells you it's a fasting test (water is okay).
- Take usual meds unless your clinician says otherwise.
- Avoid smoking and vigorous exercise just before/during the test.

What it feels like:

- The drink is very sweet; some people feel queasy or light-headed.
- Plan to sit still at the lab between blood draws; bring something to read.
- Bring a snack to eat when you're done (if you were fasting).

Healthy Eating Basics

Your goals

- Keep blood glucose steady and nourish your baby.
- Eat regularly (3 meals + 2–3 snacks).
- Pair carbohydrates + protein (and a little healthy fat) to slow the rise in blood sugar.
- Choose high-fiber, lower-glycemic carbs most of the time. (Your dietitian will personalize portions for you.)

The GDM Plate Method (easy visual guide)

- ½ **plate** non-starchy vegetables (salad greens, broccoli, peppers, zucchini, green beans).
- ¼ **plate** lean protein (eggs, chicken, fish, tofu, Greek yogurt, beans/lentils*).
- ¼ **plate** high-fiber carbs (brown rice, quinoa, whole-grain bread/tortilla, sweet potato, fruit).
- Add a **thumb-size** portion of healthy fat (olive oil, avocado, nuts/seeds).

*Beans/lentils contain carbs **and** protein—count them toward your carb portion.

Smart carb choices

- Whole grains (oats, brown rice, quinoa, barley)
- Starchy vegetable in modest portions (sweet potato, winter squash, corn)
- **Whole fruit** (1 small piece or 1 cup berries)—avoid juice
- Dairy: plain milk or **Greek yogurt**; watch portions
- Aim for **≥3 g fiber/serving** when possible

What to limit

- Sugary drinks (juice, soda, sweet tea, specialty coffees)
- Large portions of white bread, white rice, regular pasta
- Sweets and pastries (cakes, donuts, candy)
- "Cereal bombs" (big bowls of refined cereal)

Timing & practical tips

- Eat **within 1 hour of waking**, then every **3–4 hours**.
- **Breakfast**: keep **carbs smaller and slower** (morning insulin resistance is common).
- **Bedtime snack**: include **protein + a small carb** (e.g., cottage cheese + ½ banana) to support overnight levels.
- Hydrate with **water or sparkling water**; keep caffeine within your provider's guidance.
- Non-nutritive sweeteners: small amounts are typically acceptable—**whole foods and water are best**. Ask your doctor if unsure.

Portions at a glance (about 15 g "carb choice")

- 1 small fruit (e.g., small apple) or 1 cup berries
- 1 slice whole-grain bread or ½ whole-grain pita
- ½ cup cooked oats, brown rice, or quinoa
- ½ cup beans/lentils
- 1 cup milk (check label)

How much carbohydrate should I aim for?

Per day: Most pregnant people need **at least 175 g of carbohydrate/day** to meet fetal brain needs. Many GDM meal plans land around **~175–210 g/day**, individualized by your dietitian.

Per meal/snack (typical ranges used by clinics):

- **Breakfast: 30–45 g** (keep breakfast carbs modest; morning insulin resistance is common)
- **Lunch: 45–60 g**
- **Dinner: 45–60 g**
- **Snacks: 15–20 g** (2–4 times/day; include a bedtime snack)

Why these ranges? Distributing carbs across **3 small–moderate meals + 2 or more snacks** helps prevent glucose spikes and supports steady energy for you and baby.

Sample day (example—your plan may differ)

- **Breakfast (≈30–40 g carbs):** 2 eggs, 1 slice whole-grain toast, ½ cup berries; coffee/tea unsweetened or with a small splash of milk.
- **Snack (≈15–20 g)**: Greek yogurt (unsweetened) + ¼ cup nuts or seeds.
- **Lunch (≈45–55 g)**: Big salad (½ plate veg) + grilled chicken; ½–¾ cup quinoa; olive-oil vinaigrette.
- **Snack (≈15–20 g)**: Small apple + 1–2 Tbsp peanut butter.
- **Dinner (≈45–60 g)**: Baked salmon; ½–¾ cup brown rice; roasted broccoli; side salad.
- **Bedtime snack (≈15–20 g)**: Cottage cheese + ½ banana or whole-grain crackers + cheese.

This sample day totals roughly **~185–215 g carbs**, which meets the pregnancy minimum and fits typical GDM meal plans. Your dietitian will adjust targets to your blood sugar results.

Beyond Carbs: Protein, Fats & Fiber

Carbohydrates

- Aim for **~175–210 g/day**, split across **3 meals + 2–4 snacks** (e.g., 30–45 g breakfast; 45–60 g lunch/dinner; 15–20 g snacks).
- Choose **high-fiber, lower-glycemic carbs**; pair with protein/fat.

Protein

- Aim for **≥71 g/day** (pregnancy minimum).
- Easy way to hit it: **20–30 g per main meal + 10–15 g per snack**.
- Good sources: eggs, Greek yogurt, cottage cheese, poultry, fish (low-mercury), tofu/tempeh, beans/lentils*.

* Beans/lentils count toward carbs and protein—watch portions.

Fats

- Aim for **~20–35% of calories** from fat.
- Focus on **unsaturated fats**: olive oil, avocado, nuts/seeds, fatty fish.
- **Limit saturated fa**t (butter, high-fat meats); **avoid trans fats** (e.g. margarine, shortening).
- Bonus: try to ge**t DHA 200–300 mg/day** (e.g., salmon 1–2×/week or prenatal with DHA).

Fiber

- Aim for **~28 g/day**. Helps blunt glucose spikes and supports digestion.
- Load up on veggies, whole grains, beans/lentils, berries, nuts/seeds.

Hydration

- Target ~**8–12 cups fluids/day** (mostly water). Dehydration can nudge glucose higher.

1 Cup = 8 ounces
8 Cups = 64 ounces
12 Cups = 96 ounces

Fluids can include water, milk, juice, soups, fruits, vegetables, and other hydrating foods. An adequate amount of water is important.

Micronutrient "essentials" (from your prenatal and food)

- Folate 600 mcg **DFE**/day, Iron 27 mg/day, Calcium 1,000 mg/day, Vitamin D 600 IU/day, Iodine 220 mcg/day, Choline 450 mg/day.

DFE = Dietary Folate Equivalents: A unit that adjusts for the fact that your body absorbs synthetic folic acid better than natural food folate. Conversions:

- 1 mcg DFE = 1 mcg food folate
- 1 mcg DFE = 0.6 mcg folic acid (from fortified foods or a supplement taken with food)
- 1 mcg DFE = 0.5 mcg folic acid (supplement on an empty stomach)

How much in pregnancy?

Recommended is 600 mcg DFE per day in pregnancy. Practically, a prenatal with 400 mcg folic acid taken with food provides about ≈680 mcg DFE; on an empty stomach it's ≈800 mcg DFE.

Why it matters:

Getting enough folate/folic acid before and during early pregnancy lowers the risk of neural tube defects in the baby.

Examples of High-Fiber, Lower-Glycemic Carbs

Quick rules that help

- Look for ***≥3 g fiber per serving*** on the label.
- Choose ***intact/less-processed carbs*** (oats you cook, whole grains, beans).
- ***Pair with protein/fat*** to blunt spikes.

Whole grains (cooked)

- Steel-cut/old-fashioned oats – ~½ cup cooked ≈ 15 g carb
- Quinoa, barley, farro – ~½ cup cooked ≈ 18–22 g
- Brown basmati or wild rice – ~½ cup cooked ≈ 20–22 g

Breads & wraps

- ***100% whole-grain or sprouted bread*** (≥3 g fiber/slice) – 1 slice ≈ 15 g
- ***Whole-wheat pita*** (small) – ½ pita ≈ 15 g
- ***Corn tortillas*** (6") – 1–2 tortillas ≈ 12–24 g (check label)

Legumes (carb + protein + fiber)

- Lentils, black/pinto/kidney beans, chickpeas – ½ cup ≈ 15–20 g carb + 6–9 g protein + 5–8 g fiber

Starchy vegetables (watch portions)

- Sweet potato (with skin) – ½ medium or ½ cup ≈ 15–20 g
- Winter squash (butternut/acorn) – ½ cup ≈ 10–15 g
- Green peas or corn – ½ cup ≈ 15–20 g

Fruit (whole > juice)

- Berries (strawberries/blueberries/raspberries) – 1 cup ≈ 15–20 g
- Apple, pear, orange (small/medium) – 1 piece ≈ 15–20 g
- Cherries, kiwi, peach, plum – 1 cup or 2 small ≈ 15–20 g
- Tip: grapes, pineapple, and watermelon can spike faster —keep portions smaller.

Dairy & fermented options

- Plain Greek yogurt (unsweetened) – ~¾–1 cup ≈ 8–12 g carb + high protein
- Kefir, plain milk – 1 cup ≈ 12–15 g (pair with meals)

Higher-fiber snacks

- Air-popped popcorn – 3 cups ≈ 15 g carb + ~3 g fiber
- Chia pudding (2 Tbsp chia + milk) – ~10–15 g carb + omega-3 + fiber
- Rye crispbread / high-fiber crackers – check label (≥3–5 g fiber/serving)

Smart swaps

- White rice → quinoa/barley/brown basmati
- White bread → 100% whole-grain/sprouted
- Large flour tortilla → 2 corn tortillas
- Instant oats → steel-cut/old-fashioned oats
- Russet potato → sweet potato or new potatoes, cooled & reheated
- Juice → whole fruit
- Sugary cereal → oats + nuts/seeds

Portion cheat sheet (≈15 g "carb choice")

- 1 small fruit or 1 cup berries
- 1 slice whole-grain bread
- ½ cup cooked oats/rice/quinoa/barley
- ½ cup beans/lentils
- 3 cups air-popped popcorn
- 1 small corn tortilla (brand-dependent)

Your dietitian may adjust portions based on your readings. When in doubt, measure once or twice—most of us underestimate "½ cup."

Blood Glucose Monitoring

Why it matters

- Checking your blood glucose shows how your body responds to meals, activity, and (if prescribed) medication. Keeping numbers in range lowers risks for you and your baby.

When to check

- Fasting (right after waking, before eating)
- After meals: 1 or 2 hours after the start of each meal.

Target Glucose levels

- Fasting: <95 mg/dL
- 1 hour after meal: <140 mg/dL
- 2 hours after meal: <120 mg/dL

How to get accurate readings

- Wash hands with soap and water; dry well. (Fruit residue or lotions can falsely raise results.)
- Use a new lancet each time; store strips properly; follow your meter's instructions.
- If a number seems "off," repeat after washing hands again.

What to do with the numbers

- Log every result (use the log pages at the back). Note meals, activity, and any insulin/meds taken.
- If numbers are often above target, message your care team—your plan (food, timing, activity, or meds) may need an adjustment.

Comfort tips

Sit comfortably during the testing, have water available, and keep a small snack, which you can take if you feel shaky or unwell (especially if you use insulin/meds). Check your glucose and follow your team's hypoglycemia instructions.

Low Blood Sugar (Hypoglycemia): What It Is & What To Do

What counts as "low"?

- Level 1 (treat): <70 mg/dL
- Level 2 (urgent): <54 mg/dL
- Pregnancy guidelines often use the same "treat <70" threshold; your clinic may personalize this.

How low blood sugar can feel

Shaky, sweaty, fast heartbeat, hungry, dizzy/light-headed, headache, blurred vision, irritable, weak/tired, or confused. Severe lows can cause seizures or fainting (emergency).

Who is more likely to have lows?

Lows are more common if you use insulin (or certain diabetes medicines). They're uncommon with diet alone and rare with metformin by itself. Always follow your clinician's plan.

What to do right now (the 15–15 rule)

1. Take 15 g fast-acting carbohydrate, such as:
   - 4 oz (½ cup) juice or regular (not diet) soda
   - 3–4 glucose tablets (check label for 15 g total)
   - 1 tube glucose gel
   - 1 Tbsp honey or table sugar dissolved in water
   - (Avoid chocolate/ice cream for treatment—fat slows sugar absorption.)
2. Wait 15 minutes, then recheck your blood sugar.
3. If still <70 mg/dL, repeat step 1.
4. When you're back in range and your next meal is >1 hour away, eat a snack with protein + carb (e.g., cheese + crackers, Greek yogurt).

If a reading doesn't match how you feel, confirm with a finger-stick before treating whenever possible.

Safety notes

- Do not drive if you feel low or are <70 mg/dL—treat and recheck first.
- If you pass out or can't swallow, this is severe hypoglycemia—your support person should use glucagon if prescribed and call 911.

Preventing lows

- Eat on a regular schedule (3 meals + 2–3 snacks).
- Pair carbs with protein/fat; avoid big carb portions alone.
- Check before/after exercise; keep a quick sugar source with you.
- If you're having repeated lows, especially at night, contact your care team—your plan or insulin doses may need adjustment.

High Blood Sugar (Hyperglycemia): When to Act & What to Do

What counts as "high"?
Typical goals are: fasting <95 mg/dL; 1-hour <140 mg/dL; 2-hour <120 mg/dL.
Numbers above these are "high."

Common Signs
Thirst, peeing more often, fatigue, headache, blurry vision. Many people have no symptoms, which is why checking matters.

What to do for a high reading

- **If a single number is just a bit high**:
  1. Log it with what you ate and when.
  2. Take a 10–15 minute walk if your provider says it's safe.
  3. Hydrate with water and focus on a balanced next meal (carb + protein + fiber).
  4. Recheck at your next scheduled time.

- **If you see patterns (e.g., 2 or more highs in 24–48 hours, or 3+ high fasting values in a week)**:
  Message your care team. Your plan (meal timing portion sizes, activity, or medication) may need an adjustment.

When to check ketones & call
Check urine or blood ketones if you have persistent highs (e.g., >200 mg/dL), feel ill (nausea, vomiting), are unable to keep fluids down, or your clinician has asked you to monitor ketones.

- If moderate or large ketones are present → call your care team now.
- In pregnancy, ketones can rise with illness or very low carb intake; your team will guide you.

Emergency signs — seek care promptly

- Vomiting
- Abdominal pain
- Deep/rapid breathing
- Fruity breath
- Confusion
- Persistent glucose >250 mg/dL with positive ketones.

These can be warning signs of diabetic ketoacidosis (DKA), which is urgent in pregnancy.

Prevention tips

- Distribute carbs across 3 meals + 2–4 snacks; avoid large carb loads.
- Pair carbs with protein/fiber (e.g., toast + eggs, fruit + yogurt).
- Move after meals (10–15 min walk) if approved.
- Don't skip carbs entirely—pregnancy needs ~175 g/day; extreme restriction can increase ketones.
- Take medications exactly as prescribed; never adjust insulin on your own unless you've been taught how.

Medication Options (If Lifestyle Isn't Enough)

When are medications used?

If healthy eating, activity, and glucose checks still show repeated highs, your team may add medicine. Many clinics start medication if more than one-third of your fasting or post-meal readings are above target over about a week. Your plan will be individualized.

Insulin (first choice in pregnancy) - See next pages for more on this.

Metformin (when insulin isn't possible or as an add-on)

- *What it does*: Lowers liver glucose output and improves insulin sensitivity.
- *When it's used*: If you cannot take insulin, decline injections, or as an add-on to reduce insulin dose. (Some people on metformin still need insulin later.)
- *Important counseling*: Metformin crosses the placenta; most studies show good short-term safety, but long-term child data are still being studied. Discuss pros/cons with your clinician.
- *Common side effects*: Nausea, diarrhea, stomach upset—usually improve by starting low and taking with food.

What about Glyburide?

Glyburide (an oral sulfonylurea) crosses the placenta and has been linked to more neonatal hypoglycemia and macrosomia versus insulin.

Reassurance

Whichever medicine you and your team choose, good glucose control is what protects you and your baby. Many people need an adjustment or two along the way—that's normal.

Insulin (first choice in pregnancy)

- ***Why insulin?*** It *does not cross the placenta*, so it treats your glucose without directly exposing the baby. It's the *preferred first-line treatment for GDM* in U.S. guidelines.
- ***How it's used***:
  Generally:
- Fasting highs → a long-acting (basal) insulin
- at bedtime (like Lantus, Levemir, Tresiba).
- After-meal highs → a rapid-acting insulin at
- mealtimes (like Novolog, Humalog).

  Your clinician will tailor doses to your numbers

- ***What to expect***:
  Very small needles
  Teaching on where/when to inject, how to prevent/treat lows (see next page).

Store insulin as directed.

When to inject Insulin

Basal (long-acting) insulin (Lantus, Levemir, Tresiba)

- *Purpose*: keeps fasting and between-meal glucose steady.
- *Timing*: Same time every day. Many plans use bedtime if fasting numbers are high. (Some intermediate-acting plans use bedtime and morning—follow your prescription.)

Mealtime (rapid-acting) insulin (Novolog, Humalog)

- *Purpose*: Covers the rise from a meal.
- *Timing*: At the start of the meal or ~10–15 minutes before. If you're nauseated or unsure how much you'll eat, it's reasonable to dose with the first bites (your clinician will advise).
- If you use regular insulin, it's typically ~30 minutes before meals.

Don't skip the meal after a mealtime dose. If your pre-meal glucose is low, treat the low first and follow your clinician's instructions.

Where to inject (and rotate)

- *Best site in pregnancy: Abdomen (belly) at least 2 inches (5 cm) away from the belly button; it does not harm the baby.*
- *Other sites: Outer thighs, back of upper arms, upper outer buttocks/hips.*
- *Rotate within a region (move at least 1 inch from the last spot) to prevent lumps and ensure even absorption.*

How to inject (pen method)

1. Wash hands.
2. Check the insulin: right type, not expired. Clear insulins should look clear; if you use NPH (cloudy), gently roll the pen 10–20 times—don't shake.
3. Attach a new needle and prime (e.g., 2 units) until a drop appears.
4. Choose site and clean skin if instructed.
5. Insert at 90° with a short pen needle (4 mm); pinching is usually not needed with short needles.
6. Press and hold the plunger until the dose is delivered; count to 10 before removing the needle to ensure the full dose.
7. Dispose of the needle in a sharps container; don't reuse needles.

Storage & safety

- Unopened insulin → refrigerator.
- In-use pens are typically room temperature (check your pen's instructions for the number of days).
- Do not freeze or leave in heat (car, sun).
- Always carry a fast-acting sugar source (glucose tabs, juice) in case of a low glucose level.

Common tips

- Try to inject the same way each time (site, timing) for consistent results.
- Avoid injecting into scar tissue, stretch marks, or areas you'll exercise hard right away (can change absorption).
- If you're getting repeated lows or highs, contact your care team—your dose or timing may need adjustment.

Insulin FAQ

Is insulin safe for my baby?
Yes. Insulin is the preferred treatment in pregnancy when medication is needed. It does not cross the placenta, so it controls your glucose without directly exposing the baby.

Where should I inject? Is my belly safe?
Yes—your abdomen is safe in pregnancy. Inject at least 2 inches (5 cm) away from your belly button. You can also use the outer thighs, back of upper arms, and upper outer buttocks/hips. Rotate sites to avoid lumps and help insulin absorb evenly.

Does it hurt?
Most people feel only a quick pinch, especially with short pen needles (4–6 mm). Let the needle sit in place for a slow 10-count before removing to ensure the full dose goes in.

When do I take my insulin?

- Basal (long-acting): same time every day (often bedtime if fasting numbers are high).
- Mealtime (rapid-acting): right before you eat (about 0–15 minutes before the meal). If you're queasy or unsure how much you'll eat, dose with the first bites—confirm your clinic's instructions.

What if I miss a dose?
Basal: If you remember soon after, take it and resume your usual time the next day only if your clinician has taught you how. If it's close to the next dose, don't double-dose—contact your care team for your personal plan.
Mealtime: If you haven't eaten yet, take it before you start. If you already ate, follow your clinic's correction plan or message them for guidance. (Write down what happened so your team can adjust doses if needed.)

Insulin FAQ

How do I store insulin?
Keep in-use pens/vials at room temp (typically up to 28–30 days; check your product). Store unopened insulin in the refrigerator. Don't freeze or expose to heat (car, sun).

How do I avoid low blood sugars?
Eat on a schedule (3 meals + 2–3 snacks), pair carbs with protein/fat, keep a quick sugar source with you, and review patterns with your team. See "Low Blood Sugar" page for the 15–15 rule.

What are "lumps" at injection sites?
Repeated shots in the same spot can cause lipohypertrophy (thickened skin) which makes insulin absorb unpredictably. Rotate sites (move at least 1 inch from the last spot) to prevent this.

Can I travel with insulin?
Yes—keep insulin and supplies in your carry-on, bring a snack and fast-acting carb, and a note listing your medications. For time-zone changes, ask your care team how to adjust basal timing safely.

Diabetes Tech Options

Diabetes Tech Options (may not be needed for everyone)

Continuous Glucose Monitors (CGMs)

- Small sensor on the skin that checks glucose every few minutes and can give alerts for highs/lows.
- Helpful if you're on insulin or checking frequently; some clinics use CGM to fine-tune targets in pregnancy. You may still need finger-sticks to confirm unexpected readings. Coverage varies by insurer.
- Pregnancy targets with CGM commonly focus on more time in the 63–140 mg/dL range ("time-in-range"). Your team will personalize goals.

Insulin pumps (CSII) / automated systems

- Wearable devices that deliver rapid-acting insulin continuously with mealtime boluses; some systems can automate parts of dosing.
- More common in type 1 diabetes; in gestational diabetes, pumps are not first-line but may be considered in select cases (e.g., frequent injections or challenging patterns) with proper training and close follow-up.

Talk with your clinician about whether CGM or a pump fits your situation, lifestyle, and coverage. Many people with GDM do well with meter checks and injections alone.

Weekly Blood Glucose Logs
Key: PB = Post-Breakfast | PL = Post-Lunch | PD = Post-Dinner

How to use this page:
• Check fasting each morning and 1-hour or 2-hours after each main meal (your clinic will tell you which).
• Typical targets: Fasting <95 mg/dL; 1-hr <140; 2-hr <120 (your team may personalize).
• Note meals, activity, and any insulin/meds so patterns are easy to spot.

WEEK OF _____
□ 1-hour checks □ 2-hour checks

Mon: Fasting _____ | PB _____ | PL _____ | PD _____ |
Notes _____
Tue: Fasting _____ | PB _____ | PL _____ | PD _____ |
Notes _____
Wed: Fasting _____ | PB _____ | PL _____ | PD _____ |
Notes _____
Thu: Fasting _____ | PB _____ | PL _____ | PD _____ |
Notes _____
Fri: Fasting _____ | PB _____ | PL _____ | PD _____ |
Notes _____
Sat: Fasting _____ | PB _____ | PL _____ | PD _____ |
Notes _____
Sun: Fasting _____ | PB _____ | PL _____ | PD _____ |
Notes _____

Weekly notes / questions for my team:

_____
_____
_____
_____

WEEK OF _____

□ 1-hour checks □ 2-hour checks

Mon: Fasting _____ | PB _____ | PL _____ | PD _____ |

Notes _____

Tue: Fasting _____ | PB _____ | PL _____ | PD _____ |

Notes _____

Wed: Fasting _____ | PB _____ | PL _____ | PD _____ |

Notes _____

Thu: Fasting _____ | PB _____ | PL _____ | PD _____ |

Notes _____

Fri: Fasting _____ | PB _____ | PL _____ | PD _____ |

Notes _____

Sat: Fasting _____ | PB _____ | PL _____ | PD _____ |

Notes _____

Sun: Fasting _____ | PB _____ | PL _____ | PD _____ |

Notes _____

Weekly notes / questions for my team:

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WEEK OF _____

□ 1-hour checks □ 2-hour checks

Mon: Fasting _____ | PB _____ | PL _____ | PD _____ |

Notes _____

Tue: Fasting _____ | PB _____ | PL _____ | PD _____ |

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Wed: Fasting _____ | PB _____ | PL _____ | PD _____ |

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Sat: Fasting _____ | PB _____ | PL _____ | PD _____ |

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Sun: Fasting _____ | PB _____ | PL _____ | PD _____ |

Notes _____

Weekly notes / questions for my team:

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WEEK OF _____

□ 1-hour checks □ 2-hour checks

Mon: Fasting _____ | PB _____ | PL _____ | PD _____ |

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Tue: Fasting _____ | PB _____ | PL _____ | PD _____ |

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Weekly notes / questions for my team:

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WEEK OF _____

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Weekly notes / questions for my team:

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