Diabetes during Pregnancy Assessment form

(**To be completed by the patient**)

Patient Name: ____Date of Birth: _____________________
Physician Name: ____________________________ Occupation: ________________________________
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Highest grade completed: ___________
Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Other: _______________

What type of Diabetes you have: ☐ Type 1 ☐ Type 2 ☐ Gestational Diabetes
If you had diabetes prior to pregnancy, what is your most recent A1C? ___________________________
Blood glucose average at Breakfast: ______________ Lunch: ______________ Dinner: ______________
List diabetes medications: ____
____

Number of weeks pregnant: __________ Due date: _____________Number of pregnancies: __________
Number of live births: ___________Any history of gestational diabetes: ___________________________
Do you plan on breastfeeding? ☐ Yes ☐ No

In your words, what is diabetes? ____
Rate you understanding of diabetes: ☐ Good ☐ Fair ☐ Poor
What is your goal for this education session? ____

Do you monitor your blood sugar levels? ☐ Yes ☐ No
If yes, what times do you monitor: ____
What brand of meter do you use to test your blood sugar? _____________________________________

Do others live at home with you? ☐ Yes ☐ No if yes, what is their relationship to you? _____________
Do you have anyone you can identify as your support person (s)? ☐ Yes ☐ No
If yes, who are they? ____
Do you use tobacco products? ☐ Yes ☐ No If yes, how much? __________________________________
Do you drink alcohol? ☐ Yes ☐ No if yes, how many drink do you have in a week? _______________

List any health problems you have: ____
____
If you have any of the following: *Please circle*
Morning sickness Nausea/Vomiting Constipation Diarrhea Hemorrhoids
List vitamins, minerals and over-the-counter medications you are taking: _________________________
____
List any food or medication allergies you have: ____

Do you have a regular exercise routine? ☐ Yes ☐ No if yes, type of exercise: _____________________
How many days per week? ______________________How long is each session? ___________________
Describe your activity level: ☐ Light ☐ Moderate ☐ Heavy
Any reason you cannot exercise? ____

Ht. __________ Current wt.: ___________ Pre-pregnancy wt.: ___________

Have you had an excessive wt. gain of 5-10 lbs. in 1 month? ☐ Yes ☐ No

Do you follow a specific meal plan? ☐ Yes ☐ No who does the food shopping: _________________

Do you read food labels? ☐ Yes ☐ No what do you look for? ________________________________

How many days per week do you dine out? ____________

Do you drink milk? ☐ Yes ☐ No if yes, how many servings each day? ___________________________

Do you eat cheese or yogurt daily? ☐ Yes ☐ No if yes, how many serving each day? _______________

Do you eat fruit daily? ☐ Yes ☐ No

Do you eat vegetables daily? ☐ Yes ☐ No

Write down what you typically eat for meals & snacks (include beverages):

Breakfast: ____

____

Lunch: ____

____

Dinner: ____

____

Snacks: ____

____

What time do you eat: breakfast: _________ lunch: _________ dinner: _________

Patient, Please do Not Write Below this Line.

☐ Preconception/Pregnancy Care
☐ Healthy eating
☐ Exercise
☐ Self-monitoring
☐ Goal setting
☐ Possible maternal & fetal complications w/diabetes during pregnancy
☐ Proper use of medications, if ordered
☐ Emotional aspects

Educator Signature: ________________________________Date: _____________________

Educator Signature: ________________________________Date: _____________________

Sacred Heart Health System