Beaumont

GESTATIONAL DIABETES ASSESSMENT

GENERAL INFORMATION

NAME	DATE
ADDRESS (street, city, zip code)	
BIRTHDATE	AGE
PREFERRED PHONE NUMBER (including area code) ☐ Home ☐ Cell ☐ Work (_____)_____	
EMAIL	
RACE ☐ Black/African American ☐ White ☐ Hispanic ☐ Asian ☐ Native American ☐ Other _____	
MARITAL STATUS ☐ Married ☐ Divorced ☐ Widowed ☐ Single	

How many people live in your home with you? _____ Your occupation _____

Shift normally worked: ☐ Days ☐ Afternoons ☐ Midnights

Highest level of education completed:

☐ Grade school ☐ High school ☐ College ☐ Post-graduate ☐ Other _____

Preferred method of learning: ☐ lecture/discussion ☐ demonstration ☐ reading ☐ film/TV ☐ hands on

Primary language spoken _____ Primary language read_____

MEDICAL HISTORY

Do you have any medical conditions? ☐ Yes ☐ No Please list: _____

_____

Have you had any surgery? ☐ Yes ☐ No

If yes, please describe _____

Date of last influenza vaccine: _____

Please list all your medications including over the counter, herbal preparations, vitamins, and other supplements

MEDICATION	DOSE	FREQUENCY

MEDICAL HISTORY cont'd

Allergies: ☐ Yes ☐ No (including medications, foods and environmental allergies)

AGENT	REACTION

HEALTH HABITS

Do you smoke or use any type of tobacco products? ☐ Yes ☐ No

If yes, how many cigarettes (or other products) each day?_____

Do you use nicotine vaping products? ☐ Yes ☐ No If yes, frequency_____

Do you currently drink alcohol? ☐ Yes ☐ No If yes, frequency and amount_____

Do you currently use any recreational drugs? ☐ Yes ☐ No

If yes, what kind? _____ How often?_____

DIABETES HISTORY

History of diabetes ☐ Type 1 ☐ Type 2 ☐ No

Gestational diabetes in previous pregnancy? ☐ Yes ☐ No ☐ N/A

Family history of diabetes? ☐ Yes ☐ No If yes, whom _____

OBSTETRICAL HISTORY

Date of Delivery month/yr	GA weeks pregnant	Length of labor	Birth weight	SEX M / F	Vaginal or C-section	Comments / Complications

Current Pregnancy History

Due date _____ How many weeks pregnant are you? _____

Number of pregnancies you have had _____ Number of living children _____

Have you had:

High blood pressure ☐ Yes ☐ No Multiple gestation ☐ Yes ☐ No

Bleeding ☐ Yes ☐ No Preterm labor ☐ Yes ☐ No

Other, please explain_____

_____

NUTRITION HISTORY

Height _____ Current Weight _____ Pre-pregnancy weight _____

Have you lost weight during this pregnancy? ☐ Yes ☐ No If yes, when and how much_____

Have you ever followed a special diet? ☐ Yes ☐ No If yes, please describe:_____

_____

How often do you eat out in restaurants or eat fast food/take out? _____

What type of restaurants _____

Do you skip meals? (check all that apply) ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks

Do you eat/drink? (check all that apply) ☐ Eggs ☐ Milk ☐ Meat

How many average servings do you eat per day of the following:

_____Fruit _____Vegetables _____Whole grains _____Legumes _____Dairy _____Protein/meat

Have you ever met with a dietitian? ☐ Yes ☐ No If yes, explain_____

List meal and snack times and typical meals including beverages (like milk and juice) that you might have.

Time:_____ Breakfast: _____

_____

Time:_____ Lunch:_____

_____

Time:_____ Dinner:_____

_____

Time:_____ Snacks: _____

_____

Within the last 12 months have you worried that your food would run out before you had the money to buy more

☐ often true ☐ sometimes true ☐ never true

HYPOGLYCEMIC REACTIONS (Low blood glucose reactions)

Have you ever had a low blood sugar reaction? ☐ Yes ☐ No

Describe your symptoms_____

How frequent are your reactions?_____

How do you treat a low blood sugar reactions? _____

EXERCISE

Do you consider yourself: ☐ Active ☐ Sort of active ☐ Not very active

Do you exercise? ☐ Yes ☐ No If yes, please describe below:

TYPE	HOW OFTEN	HOW LONG

Is your exercise/activity limited by health problems? ☐ Yes ☐ No

If yes, how? _____

PSYCHOSOCIAL

Is there anything about your culture/religion that could affect how you manage your meal plan?

☐ Yes ☐ No If yes, describe: _____

_____

What do you perceive as the hardest thing to deal with in having diabetes during pregnancy?

_____

_____

What are your goals for gestational diabetes education? _____

_____

What information would be helpful for you to manage your diabetes during pregnancy?

_____

_____

What is your living situation today? ☐ I have a steady place to live ☐ I have a place to live today but I am worried about losing it in the future ☐ I do not have a steady place to live.

How hard is it for you to pay for the very basics like food, housing, heating and medical?

☐ very hard ☐ somewhat hard ☐ not at all hard

In the last 12 months, has the lack of transportation kept you from medical appointments, work or for getting things needed for daily living? ☐ Yes ☐ No

Other comments/concerns:_____

_____

_____

Patient Signature: _____ Date:_____

RN/RD Signature: _____ ID#: _____ Date:_____

Time of appointment: _____ Total time: _____