Gestational Diabetes History

Name:	**Date of Birth:** **Age:**
Address: _____ _____ _____	**Home phone:** **Cell phone:** **Work phone:** **Email:** **Best way to contact you:** ☐ **Home** ☐ **Cell** ☐ **Work** ☐ **Email**
OBGYN:	**Endocrinologist (if available):**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

How many people live in your household other than yourself? _____
Relationship to you?

Race/Ethnicity (check all that apply)
☐ White ☐ Native American ☐ Black or African American ☐ Multi-race
☐ Asian ☐ Hispanic/Latino ☐ Native Hawaiian or other Pacific Islander

Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes? N☐ Y☐ Please describe:

What level of schooling have you completed?
☐ Elementary ☐ High School Diploma ☐ Some College ☐ College/University Degree
☐ Technical ☐ Military Training ☐ Graduate School ☐ Other:

Occupation:

Have you had diabetes education before? ☐ No ☐ Yes How long ago?

Do you have specific educational needs? ☐ No ☐ Yes * What kind?

How do you learn best: ☐ Listening ☐ Reading ☐ Observing ☐ Doing

From whom do you get support for your diabetes? ☐ Family ☐ Co-workers ☐ Healthcare providers
☐ Support groups ☐ No one

Do you have a history of the following (check all that apply)?

☐ High blood pressure
☐ Heart Disease
☐ Abnormal lipids
☐ Circulation problems
☐ Numbness/Pain (hands/feet)
☐ Foot problems
☐ Depression
☐ Sexual Problems
☐ Thyroid disease
☐ Eye or vision problems
☐ Kidney disease
☐ Skin
☐ Dental or mouth problems
☐ Liver Disease
☐ Stomach or bowel problems
☐ Other: _____

Family History of Diabetes:
☐ Pre-diabetes
☐ Type 1
☐ Type 2
☐ Gestational Diabetes

Height:	Pre-pregnancy weight:	Current weight:
Date of last menstrual cycle:	Current weeks pregnant:	Expected due date:
How many full-term deliveries have you had?	How many premature births have you had?	How many miscarriages have you had?
Have you ever had gestational diabetes in the past? ☐ No ☐ Yes » If yes, did you take: ☐ Glyburide ☐ Insulin ☐ Other:		

Nutrition and Lifestyle

What food planning methods have you followed in the past? (Check all that apply)

☐ Calorie Counting ☐ Food pyramid/Healthy choices ☐ No method used
☐ Carbohydrate Counting ☐ Low Carbohydrate ☐ Other: _____

Typical Day Schedule: Please fill in the times of your meals and snacks, provide us with the type and amount of food you eat, this will help develop your meal plan.

	Time	Typical Meals (Best example please)
I get up at		
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Evening meal		
Bedtime snack		
I go to bed at		

How is your appetite: ☐ **not hungry** ☐ **good** ☐ **more than usual**

Are you currently experiencing: ☐ **Nausea** ☐ **Vomiting** ☐ **Diarrhea** ☐ **Constipation**

Do you have any food allergies? If yes, please list: _____

Do you have lactose intolerance? ☐No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes Amount and times per week: _____

Do you use tobacco?
☐No ☐Yes ☐ Quit
» If yes, would you like information about smoking cessation? ☐ No ☐ Yes

How many times per week do you exercise?
☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ more than 6

What type of exercise?

For how many minutes do you exercise?
☐ 1-10 ☐ 11-15 ☐ 16-30 ☐ More than 30

Is you job active or inactive:
☐ Inactive ☐ Active » Please Explain:

List your Oral Diabetes Medications: (Please include the dose and time of day that you take medicine)
List all other medications, including over-the-counter medications and vitamins:
Do you have medication allergies? ☐ No ☐ Yes *****What Kind?

Insulin (Please list the insulin you are taking, include current dose and time of day)

Type of Insulin/ Dose of Insulin	Breakfast	Lunch	Dinner	Bedtime

If you take insulin, please answer the following, **if not** skip to next section:

Are you using an insulin to carbohydrate ratio? ☐ No ☐ Yes What is the ratio? _____ Units of insulin per_____grams of carbs
Do you supplement with extra insulin when your blood glucose is high (sliding scale)? ☐ No ☐ Yes How much extra insulin do you take?_____
Where do you inject your insulin?
Where do you store unopened insulin?
Where do you store the insulin you are using?
Do you use an insulin pen? ☐ No ☐ Yes
Where do you dispose of needles/syringes/lancets?

Are you testing your blood sugar? ☐ No ☐ Yes	**What type of meter do you use?**
How many times of day do you test?	**What is your target blood glucose range?**
Has your doctor instructed you to test your urine for ketones? ☐ No ☐ Yes » If yes, what are the results?	**Do you know your Oral Glucose Tolerance Test (OGTT) results?** Fasting: _____ 1 hour: _____ 2 hour: _____ 3 hour: _____

Hypoglycemia

Have you ever experienced a low blood sugar (less than 60 mg/dl)? ☐ No ☐ Yes	How did you treat your low blood sugar?
How many times a week do you experience a low? 0 ☐ ☐ 1-2 ☐ 3-4 ☐ >5	

Most Important Concerns

What do you feel are your most important concerns in regards to managing your gestational diabetes?
What would you like to learn during your visits?

Patient Signature: _____Date: _____

****Please do not write below this line****

Clinician Assessment Summary

Education Needs/Education Plan: ☐ Diabetes Disease Process ☐ Nutritional Management ☐ Physical Activity ☐ Using Medication ☐ Monitoring ☐ Preventing Acute Complications ☐ Preventing Chronic Complications ☐ Behavior Change Strategies ☐ Risk Reduction Strategies ☐ Psychosocial adjustment

Date: _____ Clinician Signature: _____