

Name: _____

OB/GYN: _____

Consulting Specialist _____



Pregnancy and Diabetes Assessment

DIRECTIONS: Check those that apply. Comment as appropriate.

FOR Educator use only

HISTORY:

RACE/ETHNICITY _____ AGE _____

Date of last menstrual period _____ Due Date (EDC) _____

1. Type of Diabetes: Type 1 Type 2 Gestational Other _____

2. When were you diagnosed with Diabetes? (month/year) _____

3. Family history of diabetes? NO YES Who? _____

4. Do you have a Support Person? (spouse, etc) If yes, who? _____

For clinical staff only:

5. Gravida _____ Para _____ AB _____ Other _____

EDUCATION OBJECTIVES

- State the etiology of GDM & effect of pregnancy hormones on insulin resistance
- Discuss 4 adverse effects of hyperglycemia on infant and mother

MEDICAL HISTORY:

1. How often do you see your OB/GYN _____

2. Have you seen an endocrinologist? YES NO Date _____

3. Have you seen a perinatologist (High risk pregnancy doctor) YES NO

4. Check if you've ever been diagnosed with any of the following condition

High blood Pressure		Foot problems		Gestational Diabetes	
Heart Disease		Eye or vision problems		PCOS	
Numbness/pain(feet/legs)		Thyroid disease		Kidney disease	
Circulation problems		Abnormal Cholesterol		Dental problems	

5. Past OB/GYN history: _____

6. Do you smoke? YES NO If yes, how much? _____

7. Do you drink alcohol? YES NO If yes, how much and how often? _____

EDUCATION OBJECTIVES

- Review 4 risk factors for type 2 diabetes
- Discuss the relationship between GDM and type 2 diabetes
- State 2 prevention strategies for type 2 diabetes (exercise and maintaining normal weight)
- Discuss ADA recommendations for post-partum diabetes screening

MEDICATIONS:

1. Medications for Diabetes: None Oral (pills) Injections (see next page)

a. If you take pills for diabetes, what do you take, how much and how often?

Name	Dose	How often?	Times taken?

EDUCATION OBJECTIVES

- State that insulin may be required to achieve optimal glucose goals during pregnancy

Please Complete Other Side

MEDICATIONS continued:

1. What medications do you take for other conditions? _____

2. If you take insulin, what type, how many units and at what times?

Name	Dose	Times taken?	Vial or Pen
			<input type="checkbox"/> Vial <input type="checkbox"/> Pen
			<input type="checkbox"/> Vial <input type="checkbox"/> Pen
			<input type="checkbox"/> Vial <input type="checkbox"/> Pen

3. Who administers your injections? Self Other (who?) _____
4. Do you rotate sites? NO YES Where/How? _____
5. Where do you store your *UNOPENED* vials or pens? _____
6. Where do you store your *OPENED* vials or pens? _____
7. Do you use a puncture proof needle disposal container? NO YES

NUTRITION / ACTIVITY:

1. Do you follow a special diet? YES NO Describe: _____
2. Have you ever spoken with a Dietitian? YES NO
3. Who prepares meals? Self Spouse Other _____
4. Do you work outside the home? YES NO Work hours: _____
5. What type of physical activity do you do? _____
 Number of minutes and times per week: _____

MONITORING:

1. Do you test your blood sugars at home? YES NO
 Meter Name: _____ How Often? _____
2. Do you have any difficulty using your meter? YES NO
3. What is your average fasting blood sugar? _____
4. What is your most recent HbA1c (Glycosylated Hemoglobin)? _____
5. Have you ever experienced Hypoglycemia (blood sugar less than 70)? YES NO
6. Do you know the symptoms of Hypoglycemia? YES NO
7. How do you treat low blood sugar? _____
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8. Do you check your urine for ketones? _____

EDUCATION OBJECTIVES

- DEMO/Verbalize all insulin injection techniques
- State correct dosage, timing, and action of insulin
- Review/state proper sharps disposal guidelines

EDUCATION OBJECTIVES

- State 4 food groups that contain CHO
- Review portion sizes of CHO for meals and snacks
- State appropriate timing of meals/snacks to avoid elevated blood glucose excursions
- State 3 benefits of regular, weekly exercise

EDUCATION OBJECTIVES

- DEMO SMBG and record keeping
- State goals for glucose control during pregnancy, and testing schedule
- State/DEMO when to test urine for ketones
- Discuss 1 adverse effect of ketones on infant
- Review signs, symptoms, treatment, and prevention plans for hypoglycemic reactions

Date:

RN Signature:

Location(circle): C M V W