Name: _____

Date of Birth: _____ **Age:** _____

OB/GYN Physician: _____

Specialist: _____

PREGNANCY AND DIABETES ASSESSMENT

DIABETES PATIENT PROFILE: ***Patient to complete, comment as appropriate***

EDUCATOR TO COMPLETE

DIABETES HISTORY:

When were you diagnosed with Diabetes? Month _____ **Year** _____

Type of Diabetes: ☐ **Type 1** ☐ **Type 2** ☐ **Gestational**

Have you ever had gestational diabetes before? ☐ **YES** ☐ **NO**

Do you have a family history of diabetes? ☐ **YES** ☐ **NO Who?**_____

EDUCATION OBJECTIVES

- ❑ State the etiology of GDM & effect of pregnancy hormones on insulin resistance

NUTRITION HISTORY:

Height _____ **Current weight** _____ **Pre-pregnancy weight?** _____

Food allergies or intolerances? _____

Vitamins/Minerals/Supplements? ☐ **Prenatal** ☐ **Calcium** ☐ **Vitamin D** ☐ **Iron**

☐ **Other**_____

Special Dietary Needs: ☐ **Gluten Free** ☐ **Lactose Intolerance** ☐ **Low** Sodium

☐ **Low Fat** ☐ **Vegetarian: Type** _____ ☐ **Other**_____

Please check the following foods you eat daily?

☐ **Fresh fruit** ☐ **Vegetables** ☐ **Salad** ☐ **Milk/ Yogurt** _____

☐ **Whole grain bread** ☐ **Cereal** ☐ **Rice/Pasta**_____

What meals do you eat daily? ☐ **Breakfast** ☐ **Lunch** ☐ **Dinner**

When do you eat snacks? ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Never**

Usual snacks and beverages? _____

EDUCATION OBJECTIVES

- ❑ List four food categories that contain carbohydrates

OB/GYN HISTORY:

Week of pregnancy_____ **LMP** _____ **Due Date (EDC)** _____

Are you expecting? ☐ **One baby** ☐ **More than one?** _____ **(how many?)**

Have you seen a diabetes specialist? YES ☐ **NO** ☐ **Date**_____

Have you seen a high risk pregnancy doctor? YES ☐ **NO** ☐

OB history: Total pregnancies? _____ **Total births?** _____

Miscarriages_____ **Other** _____ **Any twins or triplets?** _____

Any pregnancy complications? _____

EDUCATION OBJECTIVES

- ❑ Discuss ADA recommendations for post-partum diabetes screening
- ❑ Discuss 4 adverse effects of hyperglycemia on infant and mother

Please Complete Both Sides

Name _____ Date of Birth_____

MEDICAL HISTORY:

Check if you've ever had any of the following conditions:

☐	**High Blood Pressure**	☐	**Numbness/pain of feet**	☐	**Depression/Mental Illness**
☐	**High Cholesterol**	☐	**Breathing Problems**	☐	**Celiac Disease**
☐	**Circulation Problems**	☐	**Sleep Apnea**	☐	**Weight Loss Surgery**
☐	**PCOS**	☐	**Kidney Disease**	☐	**Stomach Problems**
☐	**Thyroid problems**	☐	**Eye/vision problems**	☐	**Type? _____**
☐	**Cancer (type?)_____**			☐	**Bowel Surgery**

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 healthy weight)

MEDICATIONS:

Please write all medications here or provide a separate list.

Name	*Dose*	*How often?*	*Time taken?*

EDUCATION OBJECTIVES

- ❑ State name, dosage, & timing of diabetes pill(s)
- ❑ Discuss how diabetes pill(s) work in the body to help achieve glucose goals
- ❑ Review/state proper sharps disposal guidelines

ACTIVITY

Do you work outside the home? ☐ NO ☐ YES *Work hours:* _____

Is your job?: ☐ N/A ☐ Active ☐ Inactive

What type of exercise do you do? _____

How much? _____ minutes _____days per week

EDUCATION OBJECTIVES

- ❑ Make a realistic goal and plan for weekly exercise

MONITORING:

Do you test your blood sugars at home? YES ☐ NO ☐

Meter Name: _____ How Often? _____

What is your most recent HbA1c (Glycosylated Hemoglobin)? _____

Do you check your urine for ketones? YES ☐ NO ☐

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*

SOCIAL HISTORY

Do you smoke? ☐ NO ☐ YES _____ packs per day _____ # of years

IF NO: Did you ever smoke? ☐ NO ☐ YES When did you stop? _____

Do you drink alcoholic beverages? ☐ NO ☐ YES

Type _____ How much? _____ How often? _____

EDUCATION OBJECTIVES

- ❑ State one activity that can be done for relaxation for 30 minutes per week

Date	**Educator Signature:**	**Location(circle): C M V W**
Date	**Educator Signature:**	**Location(circle): C M V W**

Please Complete Both Sides revised 2/12/2018