

NORTHERN MONTANA HOSPITAL
DIABETES CARE SERVICES – GESTATIONAL DIABETES HISTORY

Please print your answers in **black** ink and bring the completed form with you to your first visit with the Diabetes Educator.

GENERAL INFORMATION

Name _____

Physician's name _____

Date of birth _____ Age _____

Occupation _____ Work hours _____

Last grade of school completed _____

Marital status: ___Single ___Married ___Divorced ___Widowed

How many people in your household? _____

Is there anyone who will help you with your diabetes care? ___Yes ___No

If *Yes*, who? _____

List any family members with diabetes _____

What is our expected delivery date _____ (EDC)

Race: ___Asian ___White ___Native American ___Hispanic ___Black ___Pacific Islander ___Other

KNOWLEDGE OF DIABETES

In your own words what is gestational diabetes? _____

What do you think caused your gestational diabetes? _____

How do you feel about having gestational diabetes? _____

How would you rate your understanding of gestational diabetes? ___Good ___Fair ___Poor

What is your goal for this education session? _____

NUTRITION

Height _____ Weight _____ Pre-pregnancy weight _____

Have you had an excessive weight gain of 5-10 lbs in one month? ___Yes ___No

Have you ever been given a meal plan? ___Yes ___No

If *Yes*, how many calories? _____

Who does the cooking? _____

How much milk or yogurt do you consume in 1 day on an average? _____

How many vegetables? _____

How may fruits? _____

Are you taking prenatal vitamins? _____

How many times a week do you eat away from home? _____

How is your food prepared? ___Fried ___Baked ___Broiled ___Boiled

How would you best describe your appetite? ___Good ___Poor ___Excessive(large portions)

Do you: ___Eat unplanned meals ___Nibble between meals ___Have food cravings

___Skip meals ___Use convenience foods ___Eat rapidly

List any food allergies _____

Do you have any special dietary needs or religious observations? ___Yes ___No

If *Yes*, explain _____

Are you having any problem with heart burn? ___Yes ___No

Are you having any problems with constipation? ___Yes ___No

MEDICATION

List any medications you take. (Please list the name of the medication, the dose taken, and the time taken)

Medication: _____ Dose _____ Time _____

Medication: _____ Dose _____ Time _____

Medication: _____ Dose _____ Time _____

List any drug allergies _____

EXERCISE

Do you exercise regularly? ___Yes ___No

Type of exercise(s) _____

How often do you exercise? _____

How long do you exercise? _____ What time of day do you exercise? _____

List any problems with exercise _____

MEDICAL HISTORY

How often do you have a physical examination? _____ Date of last exam _____

How often do you have an eye examination? _____ Date of last exam _____

Do you wear glasses? ___Yes ___No

How often do you have a dental examination? _____ Date of last exam _____

Have you been hospitalized within the last 12 months? ___Yes ___No

If *Yes*, describe reason(s) _____

Have you been to the emergency room within the last 12 months? Yes No

If *Yes*, describe reason(s) _____

How would you describe your general health? Good Fair Poor

Is your health important to you? All the time Sometimes Only when ill Not at all

How many times have you been pregnant? _____

How many live births have you had? _____

Have you had gestational diabetes in the past? Yes No

If *Yes*, have you performed Self Blood Glucose Monitoring? Yes No

Have you tested your urine for ketones? Yes No

Do you smoke? _____ If *Yes*, how much? _____

Do you drink alcohol? _____ If *Yes*, how much? _____

List any other medical conditions _____

Instructor Signature _____ Date _____