(Please complete the following information)

PREGESTATIONAL DIABETES HISTORY

(Revised 05/2019)

NAME: _____

BIRTHDATE: _____AGE: _____

ADDRESS: _____

_____

PHONE: Home_____ Work_____

Cell_____

Email: _____

Preferred phone to call: ❒ Home ❒ Work ❒ Cell

Obstetrician	Primary Care Provider	Endocrinologist	What is your due date? (EDC)

Pharmacy Name / Location

Number in Household _____
Who lives with you?

Marital Status
❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Cohabitating ❒ Other

Will significant other(s) participate in program?
❒ No ❒ Yes ➢ Relationship(s):_____ Names:_____

Ethnic Background (Check all that apply)
❒ Chinese ❒ Korean ❒ Japanese ❒ Filipino ❒ Native American ❒ Black or African American ❒ Multi-race
❒ Native Hawaiian ❒ Pacific Islander ❒ Hispanic / Latino ❒ Caucasian ❒ Other_____

What level of schooling have you completed?
❒ Elementary School ❒ High School Diploma ❒ Some College ❒ College / University Degree
❒ Technical / Vocational / Business ❒ Military Training ❒ Graduate School ❒ Other _____

Occupation ❒ Day Shift ❒ Evening Shift ❒Night Shift ❒ Rotating

Is your job active or inactive?
❒ Active ❒ Inactive Explain_____

What type of diabetes do you have? ❒ Type 1 ❒ Type 2 ❒ Pre-diabetes ❒ Don't know

Year diagnosed or age at diagnosis _____

Have you ever been diagnosed with other health conditions? (Check all that apply)

❒ High blood pressure
❒ Heart Disease
❒ Abnormal blood lipids (fats)
❒ Liver disease
❒ Kidney disease
❒ Asthma
❒ PCOS
❒ Eye or vision problems
❒ Stomach or bowel problems
❒ Numbness/pain (hands/legs/feet)
❒ Dental, gum, or mouth problems
❒ Depression
❒ Thyroid Disease
❒ Other _____

Family history of:
Thyroid disease ❒ No ❒ Yes
Heart disease ❒ No ❒ Yes
Diabetes ❒ No ❒ Yes If yes, list family members w/diabetes
_____
_____

Are there any problems/concerns with this pregnancy? Please explain: _____
For this pregnancy, did you have infertility treatment (such as IVF or IUI)? _____
Are you having twins or triplets? Yes _____ No _____

List past surgeries and/or hospitalizations with dates (not including child birth):
Surgery/hospitalization _____ Date:_____
Surgery/hospitalization _____ Date:_____

Do you have any medication or food allergies?
❒ No ❒ Yes ➢ What kind? _____

Please check if you take the following: ❒ Prenatal Vitamins ❒ Calcium Supplements ❒ Iron Supplements
❒ DHA ❒ Other _____
List all your prescribed and other over-the-counter medications:
_____
_____
_____

During previous pregnancies, were you treated with any of the following? (Check all that apply)
❒ N/A ❒ Insulin ❒ Glyburide
❒ Diet-controlled only
❒ Other _____

PRIOR PREGNANCY HISTORY	How many full term deliveries have you had?	How many premature babies have you had?	How many abortions have you had?	How many miscarriages have you had?

Have you had any complications in prior pregnancies? (Check all that apply)
❒ Small size baby ❒ Premature birth ❒ Large size baby (9 pounds or more) ❒ Preterm labor
❒ Pre-eclampsia (toxemia, high blood pressure) ❒ Still birth ❒ Other (please explain) _____

List your living children: ❒ None

Name	Age	Birth weight	Was the baby full term or premature?	Vaginal delivery or C-section?

Are you aware of the impact of diabetes on pregnancy and the baby? ❒ No ❒ Yes
What method of birth control do you plan to use after delivery? _____

(Please fill-in name, birthdate, and age)

NAME: _____

BIRTHDATE: _____ AGE: _____

DIABETES MANAGEMENT HISTORY

Pregestational

Do you have a meal plan for diabetes? ❒ No ❒ Yes If yes, what? (Check all that apply) ❒ Calorie counting ❒ Exchange lists ❒ Food pyramid/healthy choices ❒ Low carbohydrate ❒ Carbohydrate counting ❒ No added sugar ❒ Other _____	Do you do your own food shopping? ❒ No ❒ Yes Do you cook your own meals? ❒ No ❒ Yes How often do you eat out? ❒ Never ❒ Once/week ❒ 2 to 4 x/week ❒ More than 4x/week ❒ Other _____
How often do you use this meal plan? ❒ Never ❒ Seldom ❒ Sometimes ❒ Usually ❒ Always	Do you read and use nutrition food labels as a dietary guide? ❒ No ❒ Yes

Typical Day Schedule: Please fill in the times of your meals and snacks. Give an example of the type and amount of food and drink you have for meals and snacks.

	TIME	TYPICAL MEALS – Example of 1 typical day and include amounts
I get up at		
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Dinner		
Evening/bedtime snack		
I go to bed at		

Do you exercise? ❒ No ❒ Yes If yes, what types?
❒ Walking ❒ Biking ❒ Active jog ❒ Swimming ❒ Sports ❒ Aerobic machine
❒ Other _____

How many times per week do you exercise? ❒ 0 ❒ 1 – 2 ❒ 3 – 4 ❒ 5 – 6 ❒ more than 6	For how many minutes per time? ❒ 0 ❒ 1 – 10 ❒ 11 – 15 ❒ 16 – 30 ❒ more than 30

Have you been advised by a physician to limit your exercise during pregnancy? ❒ No ❒ Yes If yes, please explain _____

When not at work, how many hours a day are you inactive? (TV, computer, reading, etc.)

What is your height?	What was your weight before this pregnancy? What is your current weight?	Do you have a weight gain goal for pregnancy? ❒ No ❒ Yes If yes, what is it? _____ pounds
Did you lose weight during this pregnancy? ❒ No ❒ Yes		Is weight gain a concern to you? ❒ No ❒ Yes

Do you have any problems with nausea or vomiting? ❒ No ❒ Yes

Do you have any other nutrition concerns? ❒ No ❒ Yes If yes, please explain _____

Do you use alcohol? ❒ No ❒ Yes If yes, typical amount and times per week _____

Do you use tobacco? ❒ No ❒ Yes If yes, amount	Former tobacco user? ❒ No ❒ Yes ❒ Quit Quit date:_____

Do you use street drugs? ❒ No ❒ Yes If yes, type _____

(Please fill-in name, birthdate, and age)

NAME: _____

BIRTHDATE: _____ AGE: _____

LIFESTYLE AND BEHAVIORAL ASSESSMENT

Pregestational

Check each of the items below that apply to you.

Do you check your blood glucose now? ❒ No ❒ Yes

If yes, how often do you check?
❒ Once/day ❒ 2 x/day ❒ 3 or more x/day
❒ 1 or more x/week ❒ occasionally

When do you check your blood glucose? (Check all that apply)
❒ Fasting ..... Usual result _____mg/dl
❒ Before meals..... Usual result _____mg/dl
❒ After meals..... Usual result _____mg/dl
❒ Before bedtime..... Usual result _____mg/dl
❒ Other _____

What meter(s) do you use? (List all if you have more than 1) _____

_____

Do you use a meter that checks your blood ketone levels? ❒ No ❒ Yes

What is your target blood glucose range for the following? ❒ I don't know
Fasting/before meals _____mg/dl

After meals _____mg/dl

In the last month, how often have you had a low blood sugar reaction (hypoglycemia)? ❒ Never ❒ Once ❒ One or more/week

What symptoms do you have when you are low?

How do you treat your low blood sugar or what do you take when you are low?

Do you carry something to eat or drink that is considered a fast acting source of carbohydrate at all times to treat low blood sugar? ❒ No ❒ Yes

Have you ever had a blood glucose result greater than 300 mg/dl or your meter shows "HIGH" or "HI" in the display after testing?
❒ Never ❒ Once ❒ One or more x/week

Check any of the following tests / procedures you have had in the past 12 months:

❒ Dilated eye exam Date done: _____ Name of eye doctor _____

❒ Dental exam Date done: _____

❒ Urine test for protein Date done: _____

❒ A1c Date done: _____ Result: _____%

❒ Cholesterol Date done: _____

❒ Foot exam by your doctor or foot doctor (podiatrist)

❒ Self foot exams (by yourself)

Have you had the pneumonia vaccine? ❒ No ❒ Don't know ❒ Yes, if yes when? _____
Have you had a flu shot? ❒ No ❒ Don't know ❒ Yes, if yes when? _____
Have you had a hepatitis vaccine? ❒ No ❒ Don't know ❒ Yes, if yes when? _____

In the last 12 months, have you: ❒ Used emergency services or visited the ER? ❒ Been admitted to a hospital?
Was the emergency room visit or hospital admission, diabetes-related? ❒ No ❒ Yes

Have you had previous instruction on how to take care of your diabetes? ❒ No ❒ Yes

If yes, how long ago? _____ Where? _____

(Please fill-in name, birthdate, and age)

NAME: _____

BIRTHDATE: _____ AGE: _____

LIFESTYLE AND BEHAVIORAL ASSESSMENT

Pregestational

❒ 1. Do you have problems with sleeping which is not related to the discomforts of pregnancy? (such as insomnia, sleep apnea)
❒ 2. Do you have a history of an eating disorder? (Such as anorexia, bulimia, binge eating)
❒ 3. In the last 2 weeks, have you lost interest or pleasure in doing things?
❒ 4. In the last 2 weeks, have you been feeling down, depressed, or hopeless?
❒ 5. Do you have problems with anxiety, nervousness, or stress that has affected your ability to accomplish your everyday tasks or relate to other people?
❒ 6. Do you have problems in social, school, or work environments (such as decreased productivity, avoidance, withdrawal)?
❒ 6. Do you have problems with relationships with other people (such as friends, people at school, people at work)?
❒ 7. Do you have problems within your family (such as conflict, marital conflict, issues concerning the baby's father, disciplining children)?
❒ 8. Do you have problems with financial issues (such as healthcare insurance, support for the baby, paying for infant supplies)?
❒ 9. Do you have problems with certain kinds of inappropriate or undesirable behaviors (such as aggression, over-activity, repeating behaviors you don't want to repeat)?
❒ 10. Do you have problems with addictive behavior (such as drug or alcohol abuse, gambling, workaholic behavior)?
❒ 11. Did you want this pregnancy? ❒ No ❒ Yes
❒ 12. Have you ever been involved in therapy with a counselor or psychologist? ❒ No ❒ Yes

If yes, ➢ Reason? _____
When? _____
With whom? _____
What was helpful? _____
What was not helpful? _____

MOST IMPORTANT CONCERNS ABOUT DIABETES

Please state whether you agree, are neutral or disagree with the following statements by checking the appropriate box:

- I feel good about my general health. ❒ Agree ❒ Neutral ❒ Disagree
- My diabetes interferes with other aspects of my life. ❒ Agree ❒ Neutral ❒ Disagree
- I have some control over whether I get diabetes complications or not. ❒ Agree ❒ Neutral ❒ Disagree
- I struggle with making changes in my life to care for my diabetes. ❒ Agree ❒ Neutral ❒ Disagree

My level of stress is: ❒ Low ❒ Moderate ❒ High
How do you handle stress? _____
_____

What concerns you most about your diabetes?

What is hardest for you in caring for your diabetes?

What is it like for you living with diabetes?

From whom do you get support for your diabetes? (Check all that apply)
❒ No one ❒ Family ❒ Co-workers ❒ Health care providers ❒ Support group ❒ Friends
❒ Other: _____

Are there things that get in the way of your ability to manage your diabetes? ❒ No ❒ Yes
If yes, please explain:

(Please fill-in name, birthdate, and age)

NAME: _____

BIRTHDATE: _____ AGE: _____

LEARNING NEEDS & PREFERENCES

Pregestational

What would you like to learn during your visits?

On a scale of 0 to 10, how important is it to you to make changes needed to manage your diabetes? Please circle the number.
not important at all 0 1 2 3 4 5 6 7 8 9 10 very important

On a scale of 0 to 10, how confident are you that you can make these changes? Please circle the number.
not confident at all 0 1 2 3 4 5 6 7 8 9 10 very confident

Do you have any difficulty with: ❒ Hearing ❒ Seeing ❒ Reading ❒ Speaking

Explain any checked items:

How do you learn best? (Check all that apply) ❒ Listening ❒ Reading ❒ Observing ❒ Doing

❒ Other _____

What is your language preference? ❒ English ❒ Other _____

Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes? ❒ No ❒ Yes

If yes, please explain:

Prescriptions

☐ Yes ☐ No I have prescriptions for blood sugar monitoring supplies and/or diabetes medication.
They were ordered by: _____

☐ Yes ☐ No I understand that during this pregnancy, blood sugar monitoring supplies and diabetes medication will be ordered by a doctor at the Fetal Diagnostic Institute of the Pacific.
To avoid confusion, prescriptions signed by other prescribers may be discontinued.

☐ Yes ☐ No I give the Fetal Diagnostic Institute of the Pacific and Sweet Success Hawaii permission to review the e-clinical works online external history of medications prescribed to me in the past.

Reporting/communicating with Sweet Success Team:

I will send blood sugar records mainly via: ☐ E-mail ☐ Phone call ☐ Fax

Who can we call if the Sweet Success Team **has not heard from you in more than 7 days**?

Full Name	Phone Number	Relationship

Who completed this form?	Relationship to Patient
Signature	Date