(Please complete the following information)

NAME: _____

BIRTHDATE: _____AGE: _____

ADDRESS: _____

_____

PHONE: Home_____ Work_____

Cell_____

Email: _____

Preferred phone to call: ❒ Home ❒ Work ❒ Cell

Fetal Diagnostic Institute Of The Pacific

GESTATIONAL DIABETES HISTORY

Revised 07/2014

Obstetrician	Primary Care Provider	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	Is your job active or inactive? ❒ Active ❒ Inactive ❒ Day Shift ❒ Evening Shift ❒ Night Shift ❒ Rotating Shift

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

❒	High blood pressure	❒	Eye or vision problems	Family history of:		
❒	Heart disease	❒	Stomach or bowel problems	Thyroid disease	❒ No	❒ Yes
❒	Abnormal blood lipids (fats)	❒	Numbness/pain (hands/legs/feet)	Heart disease	❒ No	❒ Yes
❒	Circulation problems	❒	Foot problems	Diabetes	❒ No	❒ Yes If yes, list family members w/diabetes
❒	Kidney disease	❒	Dental, gum, or mouth problems			_____
❒	Liver disease	❒	Depression			_____
❒	Asthma	❒	Thyroid Disease			
❒	PCOS	❒	Other _____			

Are there any problems/concerns with this pregnancy? Please explain: _____
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:_____
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
_____
_____
_____

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) _____

Have you ever had gestational diabetes in the past? ❒ No ❒ Yes
If yes, were you treated with (check all that apply):
❒ Insulin
❒ Glyburide
❒ Diet controlled only
❒ Other _____

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

(Please fill-in name and birthdate)

NAME: _____

BIRTHDATE: _____

NUTRITION AND LIFESTYLE HISTORY

GDM

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 If yes, quit date _____

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

(Please fill-in name and birthdate)

NAME: _____

BIRTHDATE: _____

LIFESTYLE AND BEHAVIORAL ASSESSMENT

GDM

Check each of the items below that may apply to you.

- ❒ 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)?
- ❒ 7. Do you have problems with relationships with other people (such as friends, people at school, people at work)?
- ❒ 8. Do you have problems within your family (such as conflict, marital conflict, issues concerning the baby's father, disciplining children)?
- ❒ 9. Do you have problems with financial issues (such as healthcare insurance, support for the baby, paying for infant supplies)?
- ❒ 10. 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)?
- ❒ 11. Do you have problems with addictive behavior (such as drug or alcohol abuse, gambling, workaholic behavior)?
- ❒ 12. Did you want this pregnancy?
  - ❒ No ❒ Yes
- ❒ 13. 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

What concerns you most about having gestational diabetes?
Are there things that get in the way of your ability to manage your gestational diabetes?
My level of stress is: ❒ Low ❒ Moderate ❒ High How do you handle stress?
From whom can you get support for managing your gestational diabetes? (Check all that apply) ❒ No one ❒ Family ❒ Co-workers ❒ Health care providers ❒ Support group ❒ Friends ❒ Other: _____

(Please fill-in name and birthdate)

NAME: _____

BIRTHDATE: _____

LEARNING NEEDS & PREFERENCES

GDM

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 gestational 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:

Who completed this form?	Relationship to Patient
Signature	Date