GESTATIONAL DIABETES EDUCATION INITIAL ASSESSMENT FORM - DIAWEB

PATIENT INFORMATION

Name:	Age:
Sex: ☐ Male ☐ Female	Date of Birth:
Home Phone:	Alternate phone:
Email Address:	

Race: ☐ White ☐ White/Hispanic ☐ Non-white Hispanic ☐ Black/Hispanic ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Biracial/Multiracial ☐ Other, Unknown, Unspecified

Primary Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ French ☐ Other:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed

Last grade of school completed: ☐ Less than High School ☐ High School/GED ☐ Trade/Vocational ☐ Some College ☐ College Degree ☐ Advanced Degree

Occupation: ☐ Manual labor ☐ Professional ☐ Self-Employed ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Student ☐ Trade/Vocational ☐ Disabled ☐ Unknown ☐ Other:

Hours worked per week: ☐ <20 ☐ 20-40 ☐ >40 ☐ N/A

Shift: ☐ Day ☐ Evening ☐ Night ☐ Rotating

Primary support person: ☐ Self ☐ Spouse ☐ Family ☐ Friend ☐ Child ☐ Parent(s) ☐ Other:

Primary caretaker: ☐ Self ☐ Spouse ☐ Family ☐ Friend ☐ Child ☐ Parent(s) ☐ Assisted Living ☐ Other:

Living Arrangements: ☐ Self ☐ Spouse ☐ Family ☐ Friend ☐ Child ☐ Parent(s) ☐ Assisted Living ☐ Group Home ☐ Other:

Learning Preference: ☐ Computer ☐ Reading ☐ Lecture ☐ Audio ☐ Hands on Demonstration ☐ Video ☐ Group Discussion ☐ No Preference

MEDICAL HISTORY

Does anyone in your family have diabetes? ☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandmother ☐ Grandfather ☐ Child/Children ☐ Multiple family members ☐ None ☐ Unknown ☐ Other:

Have you had diabetes education in the past? ☐ No ☐ Yes If yes, ☐ <1 month ago ☐ 1-3 months ago ☐ 4-6 months ago ☐ 7-12 months ago ☐ 1-2 years ago ☐ 3-5 years ago ☐ 6-10 years ago ☐ >10 years ago ☐ Unknown

Have you met with a dietitian (nutritionist) in the past? ☐ No ☐ Yes
If yes, ☐ <1 month ago ☐ 1-3 months ago ☐ 4-6 months ago ☐ 7-12 months ago ☐ 1-2 years ago ☐ 3-5 years ago ☐ 6-10 years ago ☐ >10 years ago ☐ Unknown
If so, what was the reason for the visit with the dietitian?

Do you have any of the following? ☐ Eye Disease ☐ Kidney Disease ☐ Teeth/Gum problems ☐ Numbness/tingling ☐ Heart Problems ☐ High Blood Pressure ☐ High Cholesterol ☐ Asthma/Bronchitis/COPD ☐ Liver Disease ☐ HIV/AIDS ☐ Cancer ☐ Stomach Problems ☐ Thyroid Disorder ☐ Acid Reflux/GERD ☐ Anxiety/Depression ☐ Arthritis ☐ Sexual Problems ☐ Sleep Apnea ☐ Other:

MEDICAL HISTORY *(CONTINUED)*

When is your due date?

How many weeks are you?

What date were you diagnosed with gestational diabetes during this pregnancy?

Did you have gestational diabetes with a past pregnancy? ☐ Yes ☐ No

Number of pregnancies (including this one):

Number of children born alive:

Have you delivered a baby that weighed over 9 pounds at birth? ☐ Yes ☐ No

What is your current height and weight? Height: Weight:

What was your pre-pregnancy weight?

MEDICATIONS

Medication Name	How much?	How often?	When?

Do you have any allergies to medications? ☐ No ☐ Yes If yes, list here:

Do you ever forget to take medications? ☐ No ☐ Yes If yes, why?

How many times per week do you miss a medication? ☐ Never ☐ <1 x per week ☐ 1 x per week ☐ 2-3x per week ☐ 4-6x per week ☐ 7 or more x per week

BLOOD SUGAR MONITORING

Do you check your blood sugar? ☐ Yes ☐ No

What type of meter do you have?

How often do you check your blood sugar? ☐ 1x per day ☐ 2x per day ☐ 3 x per day ☐ 4x per day ☐ >4x per day ☐ Every other day ☐ Occasionally ☐ Rarely

What time of day do you check your blood sugar? ☐ Fasting ☐ Before breakfast ☐ After breakfast ☐ Before lunch ☐ After lunch ☐ Before dinner ☐ After dinner ☐ Bedtime ☐ 12 am ☐ 3am ☐ Random ☐ Other

Current blood glucose results before meals: ___________ to ___________

Current blood glucose results after meals: ___________ to ___________

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BLOOD SUGAR MONITORING *(CONTINUED)*

Have you ever experienced hyperglycemia or high blood sugar (symptoms such as thirst, dry mouth, tiredness, frequent urination)? ☐ Yes ☐ No

How often do you have hyperglycemia? ☐ 1-3 x per week ☐ 4-6 x per week ☐ 7 or more x per week ☐ Rarely ☐ Unknown

What time of day do you experience hyperglycemia? ☐ Fasting ☐ Before breakfast ☐ After breakfast ☐ Before lunch ☐ After lunch ☐ Before dinner ☐ After dinner ☐ Bedtime ☐ 12 am ☐ 3 am ☐ Random ☐ Other

Have you ever had hypoglycemia or low blood sugar (symptoms such as sweating, anxiety, trembling, headaches)? ☐ Yes ☐ No

How often do you have hypoglycemia? ☐ 1-3 x per week ☐ 4-6 x per week ☐ 7 or more x per week ☐ Rarely ☐ Unknown

What time of day do you have hypoglycemia? ☐ Fasting ☐ Before breakfast ☐ After breakfast ☐ Before lunch ☐ After lunch ☐ Before dinner ☐ After dinner ☐ Bedtime ☐ 12 am ☐ 3 am ☐ Random ☐ Other

How do you treat hypoglycemia? ☐ Juice ☐ Soda ☐ Milk ☐ Sugar ☐ Candy ☐ Glucagon ☐ Glucose tabs ☐ Food ☐ Do nothing ☐ Other

MEDICAL MANAGEMENT

In the last 3 months, have you been a patient in an emergency room? ☐ Yes ☐ No
If yes, was the visit related to this pregnancy or gestational diabetes? ☐ Yes ☐ No

In the last 3 months, have you been admitted to a hospital? ☐ Yes ☐ No
If yes, was the hospital admission related to your pregnancy or gestational diabetes? ☐ Yes ☐ No

SELF-CARE BEHAVIOR

Do you drink alcohol? ☐ No ☐ Yes If yes, how often? ☐ Less than one drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day ☐ Social occasions

Do you use recreational drugs? ☐ Yes ☐ No

Do you carry or wear diabetes identification? ☐ Yes ☐ No

Do you participate in regular physical activity/exercise? ☐ Yes ☐ No

Do you exercise for more than 150 minutes per week? ☐ Yes ☐ No

What type of exercise do you do? ☐ Aerobics ☐ Biking ☐ Cardiac rehab ☐ Combination ☐ Running ☐ Sports/athletics ☐ Stretching ☐ Swimming ☐ Walking ☐ Weights ☐ Other

How often do you exercise? ☐ <1 per week ☐ 1-2 x per week ☐ 3-4 x per week ☐ 5-6x per week ☐ 7 or more x per week

How long do each of your exercise session last? ☐ < 15 minutes ☐ 15-30 minutes ☐ 31-45 minutes ☐ 46-60 minutes ☐ > 60 minutes

How would you rate the activity? ☐ Easy ☐ Moderate ☐ Difficult ☐ Strenuous

Do you have any physical limitations that prevent you from exercising? ☐ No ☐ Yes If yes, list:

How would you rate your current understanding of gestational diabetes? ☐ Good ☐ Fair ☐ Poor

How do you feel about gestational diabetes? ☐ Acceptance ☐ Adaptation ☐ Anger ☐ Denial ☐ Fear ☐ Guilt ☐ Overwhelmed/Confused ☐ Sadness/Depression

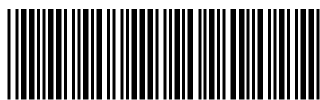
How would you rate your overall health? ☐ Good ☐ Fair ☐ Poor

How important is your health to you? ☐ Extremely ☐ Somewhat ☐ Only when ill ☐ Not important

How would you rate your stress level? ☐ High ☐ Medium ☐ Low

Does gestational diabetes interfere with anything in your life? ☐ Family/Social Activities ☐ Work/School ☐ Sports/Exercise ☐ Sexual Relations ☐ Finances ☐ Travel ☐ Nothing ☐ Other

DeKalb Medical Physicians Group
Nutrition and Diabetes Education Center



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Do you have a history of tobacco use? ☐ No ☐ Yes If yes, approximate quit date:

Do you currently smoke? ☐ Yes ☐ No

How much? ☐ occasionally ☐ <5 per day ☐ ½ pack per day ☐ ¾ pack per day ☐ 1 pack per day ☐ >1 pack per day

MEAL PLAN

Do you follow a specific meal plan? ☐ No ☐ Yes If yes,

1. What kind?
2. How well do you follow your meal plan? ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ <25%

Do you skip meals? ☐ Yes ☐ No

Who is responsible for preparing your meals? ☐ Self ☐ Spouse ☐ Both self & spouse ☐ Family ☐ Significant other ☐ Child ☐ Friend ☐ Parent ☐ In-home support ☐ Neighbor ☐ Other:________

Who is responsible for buying your food? ☐ Self ☐ Spouse ☐ Both self & spouse ☐ Family ☐ Significant other ☐ Child ☐ Friend ☐ Parent ☐ In-home support ☐ Neighbor ☐ Other:________

How often do you eat out? ☐ Daily ☐ 4-6x per week ☐ 1-3x per week ☐ Every other week ☐ Occasionally ☐ Never

Are you allergic or unable to tolerate certain foods? ☐ No ☐ Yes If yes, please explain:

Do you have any cultural or religious dietary practices? ☐ No ☐ Yes If yes, please explain:

Breakfast (Time: ______:______)

Morning Snack: (Time: ______:______)

Lunch (Time: ______:______)

Afternoon Snack: (Time: ______:______)

Dinner (Time: ______:______)

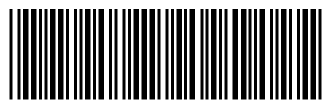
Bedtime Snack: (Time: ______:______)

Fluids:

Patient Signature: ________________________ Date: __________ Time: ________

Diabetes Educator Signature: ________________________ Date: __________ Time: ________

DeKalb Medical Physicians Group
Nutrition and Diabetes Education Center



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DMC FORM # PS-1202 (12/29/15)