

GESTATIONAL DIABETES EDUCATION INITIAL ASSESSMENT FORM - DIAWEB

PATIENT INFORMATION

Name:	Age:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Home Phone:	Alternate phone:
Email Address:	
Race: <input type="checkbox"/> White <input type="checkbox"/> White/Hispanic <input type="checkbox"/> Non-white Hispanic <input type="checkbox"/> Black/Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Biracial/Multiracial <input type="checkbox"/> Other, Unknown, Unspecified	
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Other:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Last grade of school completed: <input type="checkbox"/> Less than High School <input type="checkbox"/> High School/GED <input type="checkbox"/> Trade/Vocational <input type="checkbox"/> Some College <input type="checkbox"/> College Degree <input type="checkbox"/> Advanced Degree	
Occupation: <input type="checkbox"/> Manual labor <input type="checkbox"/> Professional <input type="checkbox"/> Self-Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Trade/Vocational <input type="checkbox"/> Disabled <input type="checkbox"/> Unknown <input type="checkbox"/> Other:	
Hours worked per week: <input type="checkbox"/> <20 <input type="checkbox"/> 20-40 <input type="checkbox"/> >40 <input type="checkbox"/> N/A	
Shift: <input type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Rotating	
Primary support person: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Child <input type="checkbox"/> Parent(s) <input type="checkbox"/> Other:	
Primary caretaker: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Child <input type="checkbox"/> Parent(s) <input type="checkbox"/> Assisted Living <input type="checkbox"/> Other:	
Living Arrangements: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Child <input type="checkbox"/> Parent(s) <input type="checkbox"/> Assisted Living <input type="checkbox"/> Group Home <input type="checkbox"/> Other:	
Learning Preference: <input type="checkbox"/> Computer <input type="checkbox"/> Reading <input type="checkbox"/> Lecture <input type="checkbox"/> Audio <input type="checkbox"/> Hands on Demonstration <input type="checkbox"/> Video <input type="checkbox"/> Group Discussion <input type="checkbox"/> No Preference	

MEDICAL HISTORY

Does anyone in your family have diabetes? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Child/Children <input type="checkbox"/> Multiple family members <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Other:
Have you had diabetes education in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> < 1 month ago <input type="checkbox"/> 1-3 months ago <input type="checkbox"/> 4-6 months ago <input type="checkbox"/> 7-12 months ago <input type="checkbox"/> 1-2 years ago <input type="checkbox"/> 3-5 years ago <input type="checkbox"/> 6-10 years ago <input type="checkbox"/> > 10 years ago <input type="checkbox"/> Unknown
Have you met with a dietitian (nutritionist) in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> < 1 month ago <input type="checkbox"/> 1-3 months ago <input type="checkbox"/> 4-6 months ago <input type="checkbox"/> 7-12 months ago <input type="checkbox"/> 1-2 years ago <input type="checkbox"/> 3-5 years ago <input type="checkbox"/> 6-10 years ago <input type="checkbox"/> > 10 years ago <input type="checkbox"/> Unknown If so, what was the reason for the visit with the dietitian?
Do you have any of the following? <input type="checkbox"/> Eye Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Teeth/Gum problems <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Heart Problems <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Asthma/Bronchitis/COPD <input type="checkbox"/> Liver Disease <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Cancer <input type="checkbox"/> Stomach Problems <input type="checkbox"/> Thyroid Disorder <input type="checkbox"/> Acid Reflux/GERD <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Arthritis <input type="checkbox"/> Sexual Problems <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other:



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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

EMORY
HEALTHCARE



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

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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: _____



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