



## GESTATIONAL DIABETES ASSESSMENT RECORD

Please complete this form and bring it with you to your appointment or class.

### 1. Patient Information:

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_

Level of Education: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Hours: \_\_\_\_\_

### 2. Gestational Diabetes History:

Type of Gestational Diabetes? ☐ Newly Diagnosed ☐ History of Gestational Diabetes

Do you have a family history of diabetes? ☐ No ☐ Yes, If yes, Who? \_\_\_\_\_

OB/Gyn Provider: \_\_\_\_\_

### 3. Gestational Diabetic Education History:

Have you ever attended a gestational diabetes education class? ☐ No ☐ Yes, if yes, Where? \_\_\_\_\_  
and When? \_\_\_\_\_

Will significant others participate in this program? ☐ No ☐ Yes, If yes, Who? \_\_\_\_\_

Level of diabetes knowledge/skill? (circle) *No understanding* 1 2 3 4 5 *Complete understanding*

Have you had education about a diet/meal planning before? ☐ No ☐ Yes, If yes, Explain: \_\_\_\_\_

### 4. Medical History:

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Weight before pregnancy: \_\_\_\_\_

Allergies: \_\_\_\_\_

Other medical problems: \_\_\_\_\_

### 5. Prenatal History:

Estimated Due Date: \_\_\_\_\_ Number of Weeks Pregnant: \_\_\_\_\_ Is this pregnancy twins or more? ☐ Yes ☐ No

Number of pregnancies including present pregnancy? \_\_\_\_\_ Number of living children: \_\_\_\_\_

Any complications during this pregnancy? ☐ No ☐ Yes, If yes, What? \_\_\_\_\_

Birth weight of child/children: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ Etc. \_\_\_\_\_

### 6. Exercise:

Do you currently have a regular exercise program? ☐ No ☐ Yes, if yes:

TYPE

LENGTH OF TIME

INTENSITY (circle)

# TIMES/WEEK

Light Medium Heavy

Did you exercise prior to pregnancy? ☐ Yes ☐ No

Have you been advised by a medical provider to limit exercise in any way? ☐ No ☐ Yes

If yes, what are the limitations? \_\_\_\_\_

### 7. Social History:

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced

Number of people that live in household: \_\_\_\_\_ Relationship/s: \_\_\_\_\_

Are they supportive and helpful? ☐ Yes ☐ No

Are you delivering at Women's Hospital? ☐ Yes ☐ No

Tobacco History: ☐ Never Smoker ☐ Former Smoker ☐ Current Smoker

### 8. Medication: Bring with you a list of all the medications you are currently taking, including over the counter (e.g. vitamins) OR list below:

Medication	Dose	Times Taken

< over >

Patient Label

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

FIN: \_\_\_\_\_ MRN: \_\_\_\_\_

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### 9. Nutrition History:

Have you or are you currently following a special diet? ☐ No ☐ Yes, If yes explain: \_\_\_\_\_

Do you skip meals? ☐ No ☐ Yes, If yes which meals? \_\_\_\_\_

Do you cook at home? ☐ No ☐ Yes \_\_\_\_\_

Do you have any food allergies? ☐ No ☐ Yes, If yes, What: \_\_\_\_\_

Do you have any strong food dislikes? ☐ No ☐ Yes, If yes, What: \_\_\_\_\_

Do you have any food you would like included/cultural influences in your meal plan? ☐ No ☐ Yes

If yes, What: \_\_\_\_\_

How often do you eat out or pick up take out? ☐ Never ☐ 1-3 times/week ☐ 4-6 times/week ☐ Daily

When eating out where do you usually dine? ☐ Fast food ☐ Sit Down Restaurant ☐ Buffet

Do you plan to breast feed? ☐ Yes ☐ No

How often in the last month did you eat or drink the following?		Never	1-6/week	1-3/day	4 or more/day
Milk, yogurt, nut/soy milk, lactose free	<input checked="" type="checkbox"/> appropriate box				
Sweetened Drinks (Pop/Soda, energy drinks, juice)	<input checked="" type="checkbox"/> appropriate box				
Fruits (Fresh, frozen, canned, dried)	<input checked="" type="checkbox"/> appropriate box				
Starchy Vegetables (Corn, Potatoes, peas)	<input checked="" type="checkbox"/> appropriate box				

In the space provided below, record what you typically eat and drink, or what you have eaten in the past 24 hours.  
Include details such as type of food and amount of food in a day.

Example:	Cereal-Cheerios - 1 Cup	Milk – Skim - 1 Cup	Toast - wheat 2 slices
Meal Times	Food Eaten and Amount		
Breakfast Time _____			
Snack Time _____			
Lunch Time _____			
Snack Time _____			
Dinner Time _____			
Snack Time _____			

### 10. Goals:

What you most interested in learning today? \_\_\_\_\_

How has Gestational Diabetes affected your life? \_\_\_\_\_

**STOP!** – Below for Diabetes RD/RN to complete.

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[Class: Group / Individual – Why; Weakness/Strengths, Cultural Influences, Barriers, Relevant History.]

CLINICIAN ASSESSMENT SUMMARY: \_\_\_\_\_

Education Needs/Education Plan: ☐ Diabetes Disease Process ☐ Nutritional Management ☐ Physical Activity

☐ Monitoring ☐ Using Medications ☐ Preventing Acute Complications ☐ Psychosocial Adjustment

☐ Preventing Chronic Complications ☐ Behavior Change Strategies ☐ Risk Reduction Strategies

Clinician Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Patient Label	
NAME: _____	DOB: _____
FIN: _____	MRN: _____

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