Document Type: Forms/Other

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	☑ appropriate box				
Sweetened Drinks (Pop/Soda, energy drinks, juice)	☑ appropriate box				
Fruits (Fresh, frozen, canned, dried)	☑ appropriate box				
Starchy Vegetables (Corn, Potatoes, peas)	☑ 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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