METHODIST
CENTER FOR DIABETES & NUTRITIONAL HEALTH

GESTATIONAL DIABETES ASSESSMENT RECORD

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

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? Yes ☐ No ☐ If yes, Who?_____
   OB/Gyn Physician:_____

3. **Gestational Diabetic Education History:**
   Have you ever attended a gestational diabetes education class? Yes ☐ No ☐
   If yes, Where? _____ & When?_____
   Will significant others participate in this program? Yes ☐ No ☐ Who?_____
   Level of diabetes knowledge/skills? Rate on a scale of 1=No Understanding to 5= Complete Understanding___
   Have you had education about a diet/meal planning before? Yes ☐ No ☐
   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? Yes ☐ No ☐ If yes, What?_____
   Any complications with previous pregnancies? Yes ☐ No ☐ If yes, What?_____
   Birth weight of child/children #1 _____ #2 _____ #3 _____ Etc. _____

6. **Exercise:**
   Do you currently have a regular exercise program? Yes ☐ No ☐

If yes: **TYPE**	**LENGTH OF TIME**	**INTENSITY (circle)** Light Medium Heavy	**# TIMES/WEEK**
_____	_____		_____

   Did you exercise prior to pregnancy? Yes ☐ No ☐
   Have you been advised by a physician to limit exercise in any way? Yes ☐ No ☐
   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 Woman'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 (such as vitamins) OR list below.**

MEDICATION	DOSE	TIME

Patient Label

9. Nutrition History

Have you or are you currently following a special diet? Yes ☐ No ☐ If yes, explain_____
Do you skip meals? Yes ☐ No ☐ If yes, which meals?_____
Do you cook at home? Yes ☐ No☐ _____
Do you have any food allergies? Yes ☐ No ☐ If yes, What?_____
Do you have any strong food dislikes? Yes ☐ No ☐ If yes, What?_____
Do you have any foods you would like included /cultural influences in your meal plan? Yes ☐ No ☐
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 are you most interested in learning today? _____
_____

How has Gestational Diabetes affected your life?_____
_____

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

****

[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 ☐

Date: _____
Clinician Signature: _____

Patient Label

METHODIST
CENTER FOR DIABETES & NUTRITIONAL HEALTH