Date ________________

GESTATIONAL DIABETES ASSESSMENT RECORD

I. PATIENT INFORMATION

Name ________________________________ Age __________ Birth Date ____________ Race _________
Address ________________________ Telephone (H) ____________________ (W) ____________________
Level of Education ________________________ Marital Status (circle) S M W D
Physician's Name ________________________ Occupation ______________________ Hours Worked ________

II. HISTORY

Height ________ Weight ______ Wt. Before Pregnancy ________ Desired Weight _________ Your Birth Wt. ___________
Allergies ____
Medications you are taking now ____
Current tobacco use? Y N Previous tobacco use? Y N
Other Medical Problems ____
Family History of Diabetes Y______N If yes, whom? ______________________________________
Date Glucose Tolerance Test Completed ________________ Result FBS/ ____1 hr ____ 2hr ____ 3hr ____
Prior Diabetes Education ____Y ____N When________________ Where________________________________
Describe your level of diabetes knowledge/skills____
Are there any cultural influences in your life we should know about to better plan your care? ___Y ___N If yes, please describe
____

III. PRENATAL HISTORY

Estimated Due Date ___________________ Number of Weeks Pregnant ______________ Is this pregnancy twins or more? __________
Previous History of Gestational Diabetes _______Y______N
Number of pregnancies including present pregnancy ________ Number of living children _______________
Miscarriages ___________
Have there been any complications during this pregnancy and any previous pregnancies _______Y______N
If yes, please explain ____
Birth weight of child/children #1 _____ #2 _____ #3 _____ Etc. ___________
Health services you are using____
Number in household:____ Relationship____
Are they supportive and helpful? ____Y ____N

IV. EATING HABITS

Do you follow a special diet? _______Y______N
Indicate times of: Breakfast_______ Lunch _________ Dinner _________ Snacks _
Do you skip meals? _______Y _______N
Who does the cooking at your house? _______Self _______ Spouse _______Other
Do you have food allergies or strong dislikes? Explain ____________________________________
Do you have favorite foods you would like to include in the meal plan? _______Y _______N
Previous education about diet and meal planning - Explain ___________________________________
Do you drink alcohol? _______Y______N
Do you plan to breastfeed your baby? _______Y______N

V. PHYSICAL ACTIVITIES/HABITS

Do you have a regular exercise program? _______Y______N Did you exercise prior to pregnancy? ______Y ______N

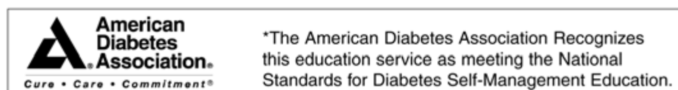
TYPE	*LENGTH OF TIME*	*INTENSITY (circle)*	*# TIMES/WEEK*
____________________	____________________	*Light Medium Heavy*	____________________

I. GOALS

What do you hope to learn or gain from these classes/sessions? (i.e., meal planning system, workable exercise planning system, blood glucose monitoring, prevention of complications)

1. ____
2. ____
3. ____

How has Gestational Diabetes effected your life? ____



NUTRITION HISTORY

Please complete the area below and indicate how you were eating before seeing your doctor. Record how you typically eat, not what you think you should be eating. Be sure to include the exact **type** and **amount** of foods eaten. If your intake varies a lot between weekdays and weekends, give an example of each type of day.

Example: *Mashed Potatoes - 1/2 C*
Roast Beef - 2 oz.

Meal Times	Food Eaten	Quantity	Food Eaten	Quantity
Breakfast Time _______				
Snack Time _______				
Lunch Time _______				
Snack Time _______				
Dinner Time _______				
Snack Time _______				