



Gestational Diabetes Assessment

Please complete front and back of this form

Date _____

Demographics:

Name _____ Date of birth _____

Age _____ Doctor _____

Occupation _____ Work Hours _____

Who lives with you? _____

Who is your main support person? _____

Have you had Gestational Diabetes with a previous pregnancy? _____

If so, when and treatment used? _____

How many weeks gestation are you today? _____

Height _____ Current Weight _____ Pre-pregnancy weight _____

Any changes noted in weight before pregnancy? _____

Meal Planning and Exercise:

Who does your grocery shopping/cooking? _____

How many times each week do you eat out? _____

Any current food limitations or food allergies? _____

Do you have any special dietary needs or religious observations? _____

List beverages: _____

How much milk or yogurt do you consume in 1 day on average? _____

When do you drink milk or eat yogurt? (Circle) Breakfast, Lunch, Dinner, Snack time

How many fruits do you eat each day? _____ When? _____

List typical snacks: _____

Current physical activity schedule? If so, describe type and frequency. _____

Monitoring and Self-Care:

Do you check blood sugars at home? _____ Meter used _____

General Health:

Health conditions other than gestational diabetes:

Do you smoke? ___ How many packs per day? ___ For how long? _____

Do you drink alcohol? ___ What type? ___ How much? _____

List any allergies to medications _____

List all medications, vitamins, or herbs that you are currently taking (include doses and how often):

Prenatal vitamins _____

Learning needs/goals:

How many years of school did you complete? _____

Do you have any learning disabilities (dyslexia) or problems with vision, hearing, or reading?
Please explain _____

What topics are you most interested in?

Food Monitoring Physical Activity

If your insurance is in another name, please provide the following:

Name: _____

DOB: _____

Place of employment: _____

SS#: _____

Diabetes Treatment Center Staff Only: *signature indicates completion of face-to-face assessment*

Reviewer's signature/title and date:

RSF DTC 2014