St. Francis Hospital
DIABETES TREATMENT–
EAST MEDICAL OFFICE BUILDING

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: _____

RSFH DTC 2021