005 PATIENT HEALTH PROFILE

St.Vincent
DIABETES CENTER
8220 Naab Rd., Suite 102
Indianapolis, IN 46260-1933
Phone: (317) 338-2349

Addressograph

GESTATIONAL DIABETES ASSESSMENT

General Information:

Name:____

Date of Birth:_______________________________________

1. Last level/grade of school completed: ☐ Post Graduate ☐ College ☐ High school ☐ Technical
   ☐ GED ☐ Grammar ☐ Other
2. How do you learn best? *(please check all that apply)*
   ☐ Reading ☐ Demonstration ☐ Lecture/Discussion ☐ Visual ☐ Other ____________________________
3. Do you have any learning barriers? *(describe)* ____
4. Primary language spoken ____________________________________
5. Are you employed outside the home? ☐ Yes ☐ No
   If yes, what is your current occupation? _____________________
   I start work at: _____________am/pm.
   I get off work at: ____________am/pm.
6. What time do you wake up? _________________________
7. What time do you usually go to bed? __________________
8. How many people are in your household? ______________
9. Is there anyone who will help you with your diabetes care? ☐ Yes ☐ No
10. Do you have any family members with diabetes? ☐ Yes ☐ No ☐ I don't know
11. How many weeks pregnant are you? __________________
12. What is your expected due date? __________________
13. Are you expecting more than one baby? (please check one)
    ☐ No ☐ I don't know ☐ Twins ☐ Triplets ☐ More

Knowledge of Diabetes:

1. Have you had gestational diabetes before? ☐ Yes ☐ No
   If yes, have you had gestational diabetes EDUCATION before? ☐ Yes ☐ No
   If yes, where and when? ____

2 Are you testing your blood sugar? ☐ No ☐ Have in past ☐ Yes Type meter using ____________________
If yes, are you on insulin? ☐ Yes ☐ No
Any problems testing? ☐ No ☐ Yes Describe ____

3. In your own words, what is gestational diabetes? ____
____

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4. What do you think caused your gestational diabetes? ______________________________

5. How do you feel about having gestational diabetes? ______________________________

6. How would you rate your understanding of gestational diabetes?
   (please check one) ☐ Good ☐ Fair ☐ Poor

7. What is your goal for this education session? ______________________________

Nutrition:

1. Height: ________ Weight: __________ Pre-pregnancy weight: ____________

2. Have you ever had any diet education? ☐ Yes ☐ No
   If yes, from whom? ____________________________ When? __________________

3. Have you ever been on a weight loss diet program? ☐ Yes ☐ No
   If yes, what program? ______________________________

4. Have you ever been on a diet for medical reasons? ☐ Yes ☐ No
   If yes, what diet? ______________________________

5. Describe your usual meals and snacks.
   __________ (Time) Breakfast: ______________________________
   __________ (Time) Snack: ______________________________
   __________ (Time) Lunch: ______________________________
   __________ (Time) Snack: ______________________________
   __________ (Time) Dinner: ______________________________
   __________ (Time) Snack: ______________________________

6. Who does the cooking? ______________________________

7. On average, how many milk, yogurt, and/or cheese servings do you eat in one day?______________

8. On average, how many vegetable servings do you eat in one day?______________

9. On average, how many fruit servings do you eat in one day?______________

10. How many times a week do you eat away from home? ______________
    Type of meal when you eat away from home: ☐ Cafeteria Style ☐ Sit-down ☐ Fast food
    ☐ Take your lunch ☐ Frozen Meals (brand:________________________)
    ☐ Other:______________________________

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11. How is your food usually prepared? ☐ Fried ☐ Baked ☐ Broiled ☐ Boiled ☐ Grilled

12. How would you best describe your appetite? ☐ Good ☐ Poor ☐ Always Hungry

13. Do you: ☐ Eat unplanned meals ☐ Nibble between meals
☐ Have food cravings ☐ Skip meals ☐ Use convenience foods ☐ Eat too fast

14. List any food allergies/intolerances: ______________________________

15. Do you have any special dietary needs or religious observations? ☐ Yes ☐ No
If yes, explain: ______________________________

16. Are you having any problems with heartburn? ☐ Yes ☐ No

17. Are you having any problems with constipation? ☐ Yes ☐ No

18. Are you having any problems with nausea or vomiting? ☐ Yes ☐ No
If yes, explain: ______________________________

Medication:

1. List any medication(s) you take: (Please list the name of the medication, the dose taken, and the time taken.)
Prenatal vitamin ☐ Yes ☐ No
Medication: ______________________ Dose:__________ Time:__________
Medication: ______________________ Dose:__________ Time:__________
Medication: ______________________ Dose:__________ Time:__________
Medication: ______________________ Dose:__________ Time:__________
Medication: ______________________ Dose:__________ Time:__________
Supplements: ______________________ Dose:__________ Time:__________
Supplements: ______________________ Dose:__________ Time:__________

2. List any drug allergies: ______________________________
____

Exercise:

1. Do you exercise regularly? ☐ Yes (If yes, see below) ☐No
☐ Type of exercise(s)? ______________________________
☐ How often do you exercise? ______________________________
☐ How long do you exercise? ______________ What time of day do you exercise? ______________

2. Does your doctor have you on any activity restriction? ☐ Yes ☐ No

3. List any other problems/limits with exercise that you may have: ______________________________
____

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Medical History:

1. How often are you seeing your doctor for this pregnancy? ______________________

2 How often do you have your eyes checked? ______________________
Date of last dilated eye exam: ______________________
Do you wear glasses/contacts? ☐ Yes ☐ No

3. How often do you have a dental checkup? ______________________
Date of last exam: ______________

4. Have you been hospitalized within the last 12 months? ☐ Yes ☐ No
If yes, describe reason(s): ____

5. Have you been to the emergency room within the last 12 months? ☐ Yes ☐ No
If yes, describe reason(s): ____

6. Is your health important to you? ☐ All the time ☐ Sometimes ☐ Only when ill ☐ Not at all

7. Before this pregnancy, have you ever been told you had any of the following:
☐ High blood sugar ☐ Low blood sugar ☐ Diabetes ☐ Polycystic Ovary Syndrome (PCOS)
Explain: ____

8. Do you smoke? ☐ Yes ☐ No If yes, how much? ______________________________
If yes, are you interested in information about how to stop smoking? ☐ Yes ☐ No

9. Do you drink alcohol? ☐ Yes ☐ No
If yes, what and how much? ____

10. How would you describe your general health? ☐ Good ☐ Fair ☐ Poor

11. List any other medical conditions: ____
____

Patient Signature: ______________________________ Date: ______________

FOR OFFICE USE ONLY

Current Labs:

OGTT Fasting	OGTT 1-hour	OGTT 2-hour	OGTT 3-hour

Instructor Signature ______________________________ *Date:* ____________
Instructor Signature ______________________________ *Date:* ____________
Instructor Signature ______________________________ *Date:* ____________

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