1113001

HILLCREST HEALTHCARE SYSTEM
TULSA, OKLAHOMA 74104

GESTATIONAL DIABETES ASSESSMENT
HMC3001 (05/16)

CLIENT INFORMATION:

Name: _____ Date: _____

Home Phone: _____ Work Phone: _____

Email: _____ May we contact you by email? □ Yes □ No

Physician's Name: _____

What is your goal for this education session? _____

NUTRITION:

Age: _____ Height: _____ Pre-pregnancy Weight: _____ Current Weight: _____ Due Date: _____

Since becoming pregnant, have you had weight gain of 5-10 pounds in one month? □ Yes □ No

Do you skip meals? □ Yes □ No Who does the cooking? _____ For how many? _____

Are you receiving WIC? □ Yes □ No

Do you plan to breastfeed? □ Yes □ No Would you like information on breastfeeding? □ Yes □ No

How is your food usually prepared? □ Fried □ Baked □ Broiled □ Boiled

How is your appetite? □ Good □ Poor □ Excessive (large portions)

Do you: □ Nibble between meals □ Have food cravings □ Skip meals □ Cravings _____

How many times during the week do you eat out? □ Less than four □ More than four

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

Describe your typical diet:

Meal / Snack	Food	Where Eaten
Breakfast **Time:**		
Morning Snack		
Lunch **Time:**		
Afternoon Snack		
Dinner **Time:**		
Bedtime Snack		

EXERCISE:

Do you exercise regularly? □ Yes □ No

How many times a week? _____

How long do you exercise? _____

What type of exercise? _____

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GENERAL HEALTH INFORMATION:

Do you smoke? □ Yes □ No
If yes, how often? _____
If no, have you ever smoked in the past? □ Yes □ No
Do you drink alcohol? □ Yes □ No
If yes, how often? _____
Do you use street drugs? □ Yes □ No
When was your last:
Physical exam _____
Eye exam _____
Dental exam _____
Describe your health □ Good □ Fair □ Poor
How many times have you been pregnant? _____
How many live births have you had? _____
Are you currently checking your blood sugars? □ Yes □ No
If yes, name of meter: _____

Have you had gestational diabetes in the past? □ Yes □ No
If yes, have you checked your blood glucose? □ Yes □ No
Tested your urine for ketones? □ Yes □ No
Were you on insulin? □ Yes □ No
List family members with diabetes _____
Do you have problems with your legs, feet, skin? □ Yes □ No
If yes, describe _____
Can anyone help with your diabetes care? □ Yes □ No
Who? _____
Do you get heartburn? □ Yes □ No
If yes, name of med _____
Do you have problems with constipation? □ Yes □ No
If yes, name of medications _____
_____

KNOWLEDGE OF DIABETES:

How would you rate your understanding of diabetes? □ Good □ Fair □ Poor

In your own words, what is gestational diabetes? _____

What do you think caused your diabetes? _____

How do you feel about having gestational diabetes? □ Upset □ Confused □ Indifferent □ Undecided

Are you willing to make changes in your food and exercising habits that are needed to control your blood sugar?..... □ Yes □ No

What issues might cause problems in you accomplishing your goals? □ Food □ Eating habits □ Money □ Work schedule □ Family problems □ Other _____

MEDICATIONS:

Do you take your prenatal vitamin? □ Yes □ No If no, why not? _____

List any medications you take: (include name of medication, the dose, and time taken)

Medication: _____ Dose: _____ Time: _____

Medication: _____ Dose: _____ Time: _____

Medication: _____ Dose: _____ Time: _____

Patient Signature: _____

Date/Time: _____