WELCOME ASSESSMENT: NEW PATIENT – GESTATIONAL DIABETES

Patient Name: ____ Today's Date: ____________

Date of Birth: ______________ Preferred Name: _________________________

Other household member(s): ____

Being Active/Physical Activity

☐ What physical activity do you regularly enjoy? ____________________________How often? _____________

☐ My healthcare provider has advised me to NOT exercise

☐ I am on bedrest

Pregnancy & Clinical History

List of past or current medical issues: ____

List medications, including over-the-counter medications. Also list any vitamins and supplements you are taking:

____

Diabetes type: ☐ Pre-diabetes ☐ T1 Diabetes ☐ T2 Diabetes ☐ Gestational Diabetes ☐ MODY ☐ Unsure

When were you diagnosed? ___________

Height: _______ Pre-pregnancy Weight: _________ Pregnant with 1, 2, or 3 babies? _________

Total # of pregnancies: _____ Children(s) and their age(s): ____

How many weeks pregnant are you now? _________ Due Date: _________

Planned delivery method: ☐ Vaginal ☐ C-section ☐VBAC

Date of last OB/GYN visit: _______ Next visit: _______

Date of last ultrasound ________ @ _____ weeks pregnant

If already delivered: Delivered at 39 weeks or later? ☐ Yes ☐ No

How: ☐ Vaginal ☐ C-section ☐VBAC

Are you currently breastfeeding?: ☐ Yes ☐ No

Do you plan to breastfeed this pregnancy?: ☐ Yes ☐ No

Previous Pregnancy Issues: (Check all that apply)

☐ Gestational Diabetes ☐ Incompetent Cervix ☐ Pre-Term Labor ☐ Pre-Eclampsia/Eclampsia/Toxemia

☐ Miscarriages ☐ Other: ____

Have you had any hospital/ER visits this pregnancy?: ☐ Yes ☐ No

General Health History

Yes	No		
☐	☐	Have you had a foot exam?	
☐	☐	Do you see a dentist?	[Last visit: __________]
☐	☐	Do you see an eye doctor?	[Last visit: __________]

(continued…)

Patient Label

Glucose Monitoring & Medications

Yes	No	
☐	☐	Do you have concerns regarding high or low blood sugar?
☐	☐	Have you ever had DKA? If yes, when? ____________
☐	☐	Do you ever test for ketones?
☐	☐	Do you have glucagon?
☐	☐	Do you have questions regarding managing diabetes while sick?
☐	☐	Do you have questions regarding emergency preparedness concerning diabetes?

Do you have a blood glucose meter? ☐ Yes ☐ No If yes, Brand:_____________

Do you use a Continuous Glucose Monitor (CGM)? ☐ Yes ☐ No If yes, Brand:______________

Are you currently taking any diabetes medication(s)? ☐ Yes ☐ No

If yes: ☐ Oral ☐ Insulin Injections ☐ Insulin Pump – [Brand: ____________] ☐ Other_________

In a typical week how many times do you miss taking your diabetes medication(s)? ____________________________

When do you test your blood sugars? (Select all that apply)

☐ Before breakfast/upon waking; Ranges: _________________________________

☐ Before meals; ____________ minutes before meals; Ranges: ____________________________

☐ After meals; ___________ hours after meals; Ranges: __________________________

☐ Before bedtime; Ranges: _______________________________

☐ Other; ____

Nutrition Information

Who shops for food? ☐ Self ☐ Other: ___________ Who prepares meals? ☐ Self ☐ Other: ___________

What types of food do you enjoy for:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages: ____

Do you ever fast? ☐ Yes ☐ No If so, how often and for how long? ___________________________

How frequently do you eat out? ☐ 1 – 2 times/month ☐ 1 – 2 times/week ☐ 3 – 4 times/week ☐ Daily

Favorite restaurants/fast food places: ____

Food allergies, restrictions, and/or GI issues: ____

What, if anything, makes healthy eating most challenging? _____________________________________

(continued…)

Patient Label

WELCOME ASSESSMENT: NEW PATIENT – GESTATIONAL DIABETES (cont'd…)

Nutrition Information

Are you confident in reading a nutrition facts label? ☐ Yes ☐ No ☐ Would like a review

How confident are you in making health choices? ☐ Not at all ☐ Somewhat ☐ Confident ☐ Very Confident

Do you use any of the following food assistance programs:
☐ WIC ☐ Food Stamps ☐ Meals on Wheels ☐ Food Pantry ☐ Community Meals

Would you like information on food assistance programs? ☐ Yes ☐ No

General Diabetes Education

1. Have you received education on the following topics **in the past?:** (Select all that apply)

☐ What causes diabetes	☐ Preventing and treating lows
☐ Education about your diet	☐ Complications of diabetes
☐ Exercise and diabetes	☐ Self-care and emotional health
☐ How different kinds of insulin work	☐ Setting goals for care
☐ How to check blood glucose	

2. Please list any other topics or concerns that you would like to discuss with the Diabetes Center staff during your visit:
____
____
____

3. How do you learn best? ☐Discussion ☐Demonstration ☐Reading ☐Videos/Audiovisual ☐Other______________

4. Do you have difficulty with any of the following?
☐Hearing ☐Seeing ☐Reading ☐Writing ☐Understanding ☐Listening

The information provided on this form is true and accurate to the best of my knowledge.

Patient/Representative (Printed named): ____

Patient/Representative (Signature): ____

Date: __________ Time: ____________ Relation to Patient: __________________________________

Patient Label