Diabetes Forms

Saint Luke's Health System

Diabetes Center
Gestational Diabetes Assessment

Name:_____ Birth date:_____ Age: _____ Date:_____

Obstetrician:_____ Primary doctor:_____

Occupation: _____ Work hours: _____ Daytime phone: _____

An ADVANCE DIRECTIVE is a document stating your health care choices or naming someone to make the choices for you if you become unable to do so.
Would you like information on an Advance Directive? ☐ Yes ☐ No ☐ Information provided to patient/family

Health Status

When is your baby due? _____
How many children do you have? _____
Have you previously had gestational diabetes? ☐ Yes ☐ No
Do any of your family members have diabetes? ☐ Yes ☐ No
Did any of your babies weigh 9 pounds or more at birth? ☐ Yes ☐ No
List all medications that you are taking including vitamin/mineral supplements, herbs and over-the-counter products:

_____

Do you have any medical problems? If so, please list:_____

_____

Do you have any special learning needs? ☐ Vision problems ☐ Hearing loss ☐ Other: _____ ☐ None
Do you have learning preferences? ☐ Demonstration ☐ Visual ☐ Hands on learning

Do you have any allergies: (please list): _____

Nutrition – Exercise – Lifestyle

Height: _____ Current weight: _____lbs. Pre-pregnancy weight: _____ lbs.
Are you taking a prenatal vitamin? ☐ Yes ☐ No Any problem with the vitamin? ☐ Yes ☐ No
Have you decided how you will feed your baby? ☐ breast ☐ bottle ☐ undecided
How is your appetite? ☐ hungry ☐ average ☐ poor
Do you have any of the following? ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ heartburn
Do you follow any cultural or religious food restrictions? ☐ Yes ☐ No If yes, what are they?_____

_____

_____

Which of the following describes your eating? (check all that apply):

☐ Skip meals	☐ Fast food	☐ Likes fruit and vegetables
☐ Eat too much at meals	☐ Picky eater	☐ Regular soft drinks
☐ Eat too many sweets	☐ Poor appetite	☐ Drinks milk every day

Do you drink alcohol? ☐ Yes ☐ No If yes, number of drinks per week:_____
Do you use tobacco? ☐ Yes ☐ No If yes, number of cigarettes a day:_____
Do you exercise? ☐ Yes ☐ No If yes, what do you do?_____
How many times per week do you exercise?_____
How many minutes for each exercise session?_____

Patient Label:

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Who is responsible for buying food?_____ Preparing food?_____
How often do you eat away from home?_____ Where?_____
Snack Foods:_____

How many times a week do you eat the following foods? (Circle those that apply)					
	Red Meat (hamburger, etc.)		Yogurt		Vegetables
	Pork		Oil (type?)		Fruit
	Chicken/Turkey		Salad dressing (type?)		Fruit Juice
	Fish/Tuna/Salmon		Sour Cream/Cream cheese		Pie/Cake/Candy/Cookies
	Bacon/Sausage		Butter/Margarine		Ice Cream/Frozen Yogurt/Sherbet
	Lunchmeat/Hotdogs		Beans/Lentils		Chips/Pretzels
	Peanut Butter		Bread (type?)		Alcohol (type?)
	Eggs		Cereal (type?)		Soda/Kool-Aid (Regular or Diet)
	Milk (type?)		Pasta/Rice		Coffee/Tea (with or without sugar)
	Cheese (type?)		Potatoes/French Fries		Water (How much?)

Please list what you had to eat in the past 24 hours (include times eaten):

Breakfast:

Lunch:

Dinner:

Snacks:

Additional History:

Have you ever been hit, kicked, punched, strangled, threatened or otherwise hurt by your partner/spouse? ☐ Yes ☐ No

Is your partner or spouse threatening you or otherwise making you feel afraid? ☐ Yes ☐ No

METRO WIDE ABUSE HOTLINE 816-HOTLINE (816-468-5463) Safe Home 913-262-2868 www.safehome-ks.org

In the past two months how often have you felt down, depressed or hopeless?
☐ Never ☐ Rarely ☐ Sometimes ☐ Mostly ☐ Always
In the past two months how often have you have been experiencing chronic pain?
☐ Never ☐ Rarely ☐ Sometimes ☐ Mostly ☐ Always Where?_____

Over the last two weeks have you had thoughts that you would be better off dead or hurting yourself in some way?
☐ Yes ☐ No
If yes, are you thinking about acting on any of these thoughts at this time? ☐ Yes ☐ No

Diabetes Educator Signature:_____ Date: _____Time:_____

Patient Signature:_____ Date:_____Time:_____

Patient Label: