PROVIDENCE HOSPITAL
6801 Airport Boulevard, Mobile AL 36608,
251/633−1000

Diabetes Center
Pregnancy Health Assessment

GENERAL INFORMATION

1. Name:_____Date:_____Age:_____Race:_____Sex:_____
2. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
3. Your Physician's Name:_____
4. Occupation:_____Work hours:_____
5. Last grade of school completed:_____
6. How many people live in your household?_____
7. Is there anyone who will help you with your diabetes care? ☐ Yes ☐ No
   If yes, who?_____
8. List any family members with diabetes:_____
9. What is your expected delivery date?_____Weeks Gestation_____

KNOWLEDGE OF DIABETES

1. In your own words, what is diabetes?_____
   _____
2. What do you think caused it?_____
3. How would you rate your understanding of diabetes? ☐ Good ☐ Fair ☐ Poor
4. What is your goal for this education session?_____
   _____

NUTRITION

1. Height:_____Present weight:_____ Pre−pregnancy weight:_____
2. Have you had an excessive weight gain of 5 – 10 lbs. in one month? ☐ Yes ☐ No
3. Have you ever been given a meal plan? ☐ Yes ☐ No
4. Describe your usual eating habits:

Usual Eating Habits (include amount and how prepared)		
Breakfast	Lunch	Dinner
Morning Snack	Afternoon Snack	Evening Snack

5. Who does the cooking?_____
6. How much milk or yogurt do you consume in 1 day on an average?_____
7. How many vegetables?_____
8. How many fruits?_____
9. Are you taking prenatal vitamins?_____
10. How many times a week do you eat away from home?_____
    Type of meal when you eat away from home:
    ☐ Cafeteria style ☐ Home style ☐ Fast food ☐ Sack lunch
11. How is your food usually prepared? ☐ Fried ☐ Baked ☐ Broiled ☐ Boiled
12. How would you best describe your appetite? ☐ Good ☐ Poor ☐ Excessive (large portions)

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13. Do you: ☐ Eat unplanned meals ☐ Nibble between meals ☐ Have food cravings
☐ Skip meals ☐ Use convenience foods ☐ Eat rapidly
14. Do you have any specific ethnic or cultural traditions (Examples: Jewish, Latin American, Asian, Vegetarian, etc)?_____
15. List any food allergies:_____
16. Are you having any problem with heart burn? ☐ Yes ☐ No
17. Are you having any problems with constipation? ☐ Yes ☐ No

MEDICATION

1. List any medications you take. (Please list name of medication, the dose taken, and the time taken)
Medications:_____Dose:_____Time:_____
Medications:_____Dose:_____Time:_____
Medications:_____Dose:_____Time:_____
2. List any drug allergies:_____

EXERCISE

1. Do you exercise regularly? ☐ Yes ☐ No
Type of exercise(s)_____
How often do you exercise?_____
How long do you exercise?_____What time of day do you exercise?_____
2. List any problems with exercise:_____
_____

MEDICAL HISTORY

1. List any other medical conditions:_____
_____
2. Do you have blurred vision? ☐ Yes ☐ No
3. Have you been hospitalized within the past 6 months? ☐ Yes ☐ No
If yes, describe reason(s):_____
4. Have you been to the emergency room within the last 6 months? ☐ Yes ☐ No
If yes, describe reason(s):_____
5. How would you describe your general health? ☐ Good ☐ Fair ☐ Poor
6. Is your health important to you? ☐ All the time ☐ Sometimes ☐ Only when ill ☐ Not at all
7. How many times have you been pregnant?_____
8. How many live births have you had?_____
Birthweights:_____
9. Did you have diabetes prior to this pregnancy? ☐ Yes ☐ No
If yes, have you checked your own blood sugar before? ☐ Yes ☐ No
Have you tested your urine for ketones? ☐ Yes ☐ No
10. Do you smoke?_____If yes, how much?_____
11. Do you drink alcohol?_____If yes, amount and type:_____

_____
Educator Date

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Diabetes Center
Gestational Consultation Summary

DATE:_____

PT NAME:_____ Ht:_____ WT:_____/_____ BG:_____
USUAL / PRESENT

REFERRING MD:_____ DOB:_____

TIME SPENT :_____ DUE DATE:_____
WEEKS GESTATION:_____

ENTER CODE FOR EACH TOPIC: C=COMPETENT, RA=REQUIRES ASSISTANCE,
NA=NOT APPLICABLE, NC=NOT COVERED

Plan: Circle Objectives Taught	CODE	COMMENTS
GESTATIONAL/PRE−GESTIONAL DM OVERVIEW 1. Describe normal metabolic changes that take place in pregnancy. 2. Interpret results and meaning of the OGTT. 3. Identify potential complications of GDM.		
SELF−MANAGEMENT 1. Nutrition therapy a. State importance of nutrition and describe appropriate meals/snacks using meal plan and carb counting system. b. Define weight−gain goals during pregnancy. 2. Exercise a. Describe benefits. b. State contraindications. 3. Emotional support a. Identify needs.		
SELF−MONITORING BLOOD GLUCOSE 1. State/demo correct use of equipment. 2. State when to test, blood glucose goal range, and when to report to HCP. 3. Define ketones and importance of testing.		
INSULIN THERAPY 1. State name/dose/schedule/action & side effects of insulin. 2. Correctly demonstrate insulin administration.		
POST−PARTUM CONCERNS 1. State need for annual DM screening. 2. ID modifiable risk factors for DM.		

PROGRESS NOTES: _____

_____

_____

_____

_____ _____

Diabetes Educator Diabetes Educator

Developed 2/02, Reviewed 1/07

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Meal Plan

Name _____ **Date** _____ **Nutritionist** _____ **Phone** _____

Remember!!!!! 1 Carbohydrate Choice = 15 grams of Carbohydrate
1 Fat Choice = 5 grams of Fat

Total Needed for Each Day: _____ Carbohydrate Choices (____ grams carboydrate)
_____ Fat Choices (____ grams fat)

Breakfast	Lunch	Supper
_____ Carbohydrate Choices	_____ Carbohydrate Choices	_____ Carbohydrate Choices
_____ Grams(g) of Carbs	_____ grams(g) of Carbs	_____ grams(g) of Carbs
_____ Non−starchy Vegetables	_____ Non−Starchy Vegetables	_____ Non−starchy Vegetables
_____ Meat (s)	_____ Meat (s)	_____ Meat (s)
_____ Fat (s)	_____ Fat (s)	_____ Fat (s)

Morning Snack	Afternoon Snack	Evening Snack
_____	_____	_____
_____	_____	_____

Diabetes Center

Patient Outcome Data

Patient Name: _____ DOB: _____ OPP: _____ Consult: _____

Program Start Date: _____ Post Program Date: _____

Clinical Data

Clinical Indicator	Weight	Foot Inspection	Goal	Goal	Goal	Goal	Gestational Birth Weight
Pre–program		Y N	Nutrition	Exercise	SBGM	Medications/Lifestyle	
Post–program		Y N	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	

Goal Achievement: 4 = always
3 = most of the time
2 = sometimes
1 = never

DCTR0005

Revised 7/05, 1/07

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Diabetes Center

Patient Name: ,_____
Date of Birth:_____

Dear Diabetes Center Participant,

We are interested in how you are doing!

Our hope is that you have now delivered a healthy baby. We would like to know the birth weight of you baby to help us determine the effectiveness of our program.

Please fill out the information below and send it back to us in the enclosed stamped envelope as soon as possible.

Sincerely,

Diabetes Center Staff

Delivery date: _____
Weight of baby: _____
Delivery type: vaginal_____ C−section_____
Any blood sugar problems since delivery

_____
_____
_____
_____
_____
_____