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Diabetes & Pregnancy Assessment Form — Inova Center for Wellness & Metabolic Health

Name: _____ **Today's Date:** _____ | Ht: _____ Wt: _____lbs.

I learn best by: ☐ Listening ☐ Reading ☐ Watching
Do you ever need someone to help you with written health care material?: ☐ No ☐ Yes

Allergies: ☐ No ☐ Yes: please list _____
Tobacco Use: ☐ No ☐ Yes: please list _____

Current Medications: ☐ Prenatal Vitamins ☐ Calcium ☐ Iron ☐ Other, please list:

Medication Name	Dose	Times Taken

Women's Health
Number of: Previous Pregnancies ___ Living children ___ Due date ____ Weeks pregnant ____
Infant's birth weights: _____
Previous gestational diabetes: ☐ No ☐ Yes If so, did you need: ☐ diabetes pills ☐ insulin
Complications with other pregnancies: ☐ No ☐ Yes: _____
Are you expecting: ☐ Single ☐ Twins ☐ Triplets Other _____
Weight before this pregnancy: _____

Activity During Pregnancy
Has your OB provider told you to restrict your activities? ☐ No ☐ Yes
If not, what exercise do you do now? ☐ none ☐ walk ☐ bike ☐ aerobic machine ☐ swim
☐ active job ☐ other _____ Number of days each week: _____
How many minutes each day: ☐ 1-15 ☐ 16-30 ☐ 31-45 ☐ 46-60 ☐ more than 60

Eating History
Do you drink milk? ☐ Daily ☐ Weekly ☐ Never
Food preferences: ☐ Gluten free ☐ Vegetarian ☐ Vegan
Cultural preferences:_____

Vaccines: ☐ Flu (date: _____) ☐ Pneumonia (date: _____)

Which diabetes issues are you most concerned about:
☐ Healthy eating and following my meal plan
☐ Becoming and staying physically active
☐ Taking diabetes medication if needed
☐ Others: _____
☐ Testing my blood sugar regularly
☐ Balancing stress
☐ Seeking support when I need it

(ID Label)

Living with Diabetes
During the past 2 weeks how often have you been bothered by feeling down, depressed, or hopeless? □ Not at all □ Little □ Some □ A lot – please explain:
_____

Is it difficult for you to pay for diabetes care? □ No □ Yes

Are you aware of community resources? □ No □ Yes

We are concerned about the safety of our patients so we ask every patient:
Do you feel safe at home? □ Yes □ No Do you feel safe in your neighborhood? □ Yes □ No
If you answered yes to either question, please discuss with your educator.

Participant Signature: _____ Date/Time: _____

<u>If you had diabetes before this pregnancy, please also answer the following questions:**</u>**

What type of diabetes do you have? □ Type 1 □ Type 2

What year was your diabetes diagnosed? _____

Have you ever attended a diabetes education program? □ No □ Yes **If so, when: _____**

What was the result of your last A1C test? _____% Date: _____ □ Not sure

Do you have a family history of diabetes? □ No □ Yes

Are you checking your blood sugar at home? □ No □ Yes **If so, name of meter: _____**

How many days a week do you usually check? _____ How many times each day? _____

How many times each week does your blood sugar go below 70? _____

What are your symptoms of low blood sugar: _____

Do you know when your sugar is dropping? □ No □ Yes

Do you carry a source of sugar? □ No □ Yes **If so, describe: _____**

Do you wear diabetes identification? □ No □ Yes **If so, describe: _____**

Participant Signature: _____ Date/Time: _____

Educator Signature: _____ Date/Time: _____

(ID Label)