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

For Educator Use:
Ht: _____ Wt: _____lbs.

Name: _____ **Today's Date:** _____

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 Medication, please list

Medication Name	Dose	Times Taken

Vaccines: Flu (date: _____) T-Dap (date:_____)

Women's Health
Number of: Previous: Pregnancies _____ Living children ____
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: _____ Due date: _____ Weeks pregnant: _____

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: □ 0 □ 1-2 □ 3-4 □ 5-6 □ 7
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:_____

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
Over the past 2 week, have you often been bothered by:

- How often does taking care of your diabetes interfere with your lifestyle:
  □ Not at all □ A little □ Some □ A Lot
- Have you felt sad or depressed about having diabetes:
  □ Not at all □ A little □ Some □ A Lot

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 "No" to either question, please discuss with your educator.

Participant Signature: _____ Date/Time: _____

****If you had diabetes before this pregnancy, please also answer the following questions****

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 fast acting carb? □No □Yes **If so, describe: _____**

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

Participant Signature: _____ Date/Time: _____

Educator Signature: _____ Date/Time: _____