The Diabetes Learning Center
Elmhurst Memorial Healthcare
1200 S. York, Elmhurst, IL 331-221-6440
Gestational Diabetes Assessment

Name _____ DOB _____ Date _____

Primary Language Spoken _____ Phone _____ Phone _____

Marital Status: M S W D Referring Physician _____

Occupation _____ Employer _____

Primary Support Person(s) _____Relationship _____

Due Date _____ Number of weeks pregnant _____

Glucose Tolerance Test Results: FBS _____ 1 hour _____ 2 hours _____ 3 hours _____

Allergies (List)_____

Do you have any of the following diseases or conditions (please check):

Heart Disease _____
High Blood Pressure _____
High Cholesterol _____
Stroke _____

Cancer _____
Thyroid Problems _____
Hearing Problems _____
Asthma _____

GI/Digestive Problems _____
Other_____
_____
_____

Please list all medication taken at home:

Medication	Dose	Frequency

For Revisit Use Only: Changes to Previous Home Medications:

Date	New or Changed Medication	Dose	Frequency	Initials

HEALTH HISTORY

- Have you had gestational diabetes in the past? Yes No If Yes, When _____
- Number of previous pregnancies _____ Number of living children _____
- Any complications during this pregnancy? _____
- Any complications during past pregnancies to yourself or your baby? _____
  _____
- List birth weights of all children _____
- Do you have any relatives that have diabetes? Yes No Who? _____
- Do you smoke? Yes No Amount per day _____ How many years _____
- Have you ever smoked? Yes No How long ago did you quit _____
- Have you used alcohol prior to pregnancy? Yes No Type _____
  Amount _____ How often _____
- Do you exercise regularly? Yes No
  Type _____ # Minutes _____ Frequency _____
- Do you have any exercise restrictions now? Yes No What are they? _____
- If you are not exercising, what is preventing you? _____
- Do you get enough rest at night? Yes No
- Do you have pain anywhere? Yes No Where _____ How often _____
- Using a scale of one to ten, with ten being the most intense, indicate the severity of the pain? _____

NUTRITION HISTORY

- Height_____ Weight_____ Weigh before pregnancy_____ Weight gain _____ lbs or loss _____ lbs
- Has your doctor talked to you about your weight? Yes No
- Do you have any concerns with the way that you eat now?_____
  _____
- Do you feel that it will be difficult to make healthy food choices? (explain) _____
  _____
- Do you follow any special diet:
  Low salt _____ High calorie_____
  Vegetarian _____ Low fat _____
  Low calorie _____ Other _____
- Do you get up during the night to eat? Yes No

NUTRITION HISTORY continued

- Who does most of the shopping and cooking?
  You _____ Friend _____
  Spouse _____ Other _____
  Parent _____
- Do you take any vitamins, mineral or other supplement? Yes No
  Please list _____
- Are you currently drinking any alcohol? Yes No Type _____
  Amount _____ How often _____
- Do you drink caffeinated coffee/tea/cola? Yes No Type _____
  Amount _____ How often _____
- Do you use artificial sweeteners? Yes No Which product _____
  Amount _____ How often _____
- Do you eat any meals away from home, such as fast foods, brown bag, cafeteria, buffet or other restaurant?
  Yes No If yes, which meals and how often?
  Breakfast _____ x weekly
  Lunch _____ x weekly
  Dinner _____ x weekly
- Are you experiencing any of the following?
  Nausea _____ Vomiting _____
  Heartburn _____ Constipation _____
- How many times a week do you eat these foods?
  Regularly sweetened pop or beverages _____ Cookies _____
  Ice Cream, pudding, etc. _____ Candy bars or pieces _____
  Hard candy _____ Sweets or Pastries _____
  Pie or cake _____ Other sweets _____
  Fruit juice _____ _____

CURRENT DAILY SCHEDULE

A Typical Day

Write in times.

_____ I get up
_____ Start of school / work
_____ 1st meal
_____ Snack
_____ 2nd meal
_____ Snack
_____ 3rd meal
_____ Snack
_____ Bedtime

What Time of Day Do You Exercise

Please check any that apply.

_____ Before breakfast
_____ After breakfast
_____ Before lunch
_____ After lunch
_____ Before dinner
_____ After dinner

List typical Menu for a Day
(Food and Portion Size)

Weekdays / Work Days	Weekends / Days Off
1st meal	1st meal
Snack	Snack
2nd meal	2nd meal
Snack	Snack
3rd meal	3rd meal
Snack	Snack

Department Use Only: