Diabetes in Pregnancy Self-Assessment

Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____

Current Medications / Supplements (Please list your current medications, including vitamins)

	Medication/Supplement Name	Dose	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Allergies (Please list any allergies to medication and what happens if you take that medication)

_____ _____

_____ _____

Medical History (Please circle all that apply)

PCOS (Polycystic Ovary Syndrome) Type 1 Diabetes Type 2 Diabetes High Blood Pressure

Other _____

Do you drink alcohol? (Please circle yes or no) Yes No

If yes: type? _____ how often? _____ how much? _____

Do you use tobacco? Yes No Quit – when? _____

General Information

Who came with you to this class/visit?

No one Spouse Partner Mother Father Caregiver Other: _____

Have you learned anything about diabetes before today? Yes No

If yes, how/who/where? _____

Lifestyle / Health (Please circle / answer):

Do you exercise? Yes No

What type? _____ How often? _____min/day _____ days/week

How do you rate your health? Excellent Good Fair Poor

Please rate your stress level: Low Medium High

Cause of your stress: Finances Family Health Work Other: _____

Support system: Family Friends Co-workers No One Other: _____

What are your feelings about diabetes? Frustrated Angry Guilty Other: _____

Type of work: _____

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Nutritional Assessment

Height _____ Weight (now) _____ Pre-pregnancy Weight _____

Do you limit any of these? Sugar / Salt / Fat

Who cooks? _____ How often do you **eat out** per week/month? _____

In the boxes below, describe items you would eat at breakfast, lunch and dinner. ***Your individual meal plan will be based on the information you provide.*** *Include how much you eat, condiments you use, and your drinks. If you have snacks, include what you typically eat for a snack.*

What I Usually Eat **- Food, Drinks, Amounts and Where I Eat**

Breakfast Time		Where?
Snack Time		Where?
Lunch Time		Where?
Snack Time		Where?
Dinner Time		Where?
Snack Time		Where?

Blood Glucose

Do you check your blood sugar? Yes No If yes, how often? _____

What type of meter do you use? _____

What is your usual range? Fasting (first thing in the morning): _____ After meals: _____

If you had Diabetes prior to pregnancy, when was your most recent A1C? ___/___/___ Result: ____%

Pregnancy Management (Please circle / answer):

What is your due date? _____ How many **weeks** along are you today? _____

Are you having a: Single baby Twins Triplets

Do you see a specialist (high risk baby doctor)? Yes No If yes, who? _____

How many times have you been pregnant (including now)? _____ How many live births? _____