History Questionnaire: Gestational Diabetes

Please answer the following questions to the best of your ability.

Allergies: ☐ Yes ☐ No ☐ None known. If yes, to what? _____ , _____

_____ , _____ , _____ , _____

Medical History: **Please check any conditions that you have.**

☐ No medical conditions
☐ Arthritis
☐ Bowel problem
☐ Cancer
☐ Cataracts
☐ Depression
☐ Diabetes
☐ Gout
☐ Headaches
☐ Heart disease
☐ High blood pressure
☐ Hospitalizations for diabetes
☐ Impotence
☐ Kidney disease
☐ Skin ulcer with diabetes
☐ Stroke

Surgical History: **Please check any of these that you have had.**

☐ No surgeries
☐ Abdominal surgery
☐ Appendectomy
☐ Artificial joints
☐ Back surgery
☐ Brain surgery
☐ Breast surgery
☐ Broken bones/fractures
☐ Colon surgery
☐ Cosmetic surgery
☐ Eye surgery
☐ Heart surgery
☐ Hernia surgery
☐ Hysterectomy
☐ Kidney transplant
☐ Skin biopsy
☐ Thoracic surgery
☐ Tonsillectomy
☐ Vascular surgery

Family History: **Please put a check in the square if your relative has a history of:**

Relationship	Anemia	Cancer	Diabetes	Heart Disease	High Blood Pressure	High Chol	Stroke	Thyroid
Mother								
Father								
Sister								
Brother								
Son								
Daughter								
PGMo								
PGFa								
MGMo								
MGFa								

Patient Name:_____
Date of Birth:_____
Date: _____ / _____ / _____

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Tobacco Use ☐ Yes ☐ Never ☐ Quit ☐ Passive Years? _____
Packs/day _____ Tobacco type _____
Quit date _____

Alcohol Use ☐ Yes ☐ No
Drinks/Week _____ Glasses of wine
_____ ☐ Cans ☐ Bottles of beer
_____ Shots of liquor

Recreational Drug Use ☐ Yes ☐ No

Medications

Name	Dose	Route	How often	Date started	What is it for?

Pharmacy Name :_____ Phone number: _____

Personal History:

Why are you coming to the diabetes education center today?

What is your occupation? _____
Number of hours worked in a week:_____ On what shift? _____
What school grade did you last complete? _____
How do you learn best? (please check): ☐ Listening ☐ Reading ☐ Observing ☐ Doing

Do you have any exercise or activity restrictions from your provider? ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No Type _____ How often? _____
My exercise routine is: ☐ Easy ☐ Moderately intense ☐ Very intense

Expected due date: _____ How many pregnancies have you had? _____

How many living children do you have? _____

Date of birth	Weight of baby	Problems at birth

Did you have gestational diabetes with previous pregnancies? ☐ Yes ☐ No
If yes:
Did you check your blood glucose? ☐ Yes ☐ No
Did you take insulin? ☐ Yes ☐ No

Have you had nutrition counseling in the past? ☐ Yes ☐ No

Are there any complications with this pregnancy? ☐ Yes ☐ No
If yes, what are they? _____

Preventative Health
When did you last see the eye doctor? _____
When did you last see the dentist? _____
When did you last have a flu shot? _____

Learning Needs:
What topics do you need help with or would like to learn more about? (please check)
☐ None
☐ Meal planning
☐ Physical activity
☐ Dealing with stress
☐ Blood sugar monitoring
☐ Effect of high blood glucose on baby
☐ Effect of high blood glucose on mother
☐ Risk of diabetes later in life
☐ Other_____

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Do you have any religious, cultural or personal health beliefs that you would like considered as we help you develop your diabetes care plan?
☐ No ☐ Yes If yes, what are they? _____

Do you have difficulty with (please check):
☐ Hearing ☐ Seeing ☐ Reading ☐ Speaking

Pain scale:
Are you in pain today? ☐ Yes ☐ No
If yes, on a scale of 10 to 10 (0 being no pain) how would you rate your pain?
Please circle: 0 1 2 3 4 5 6 7 8 9 10

What causes your pain?_____

Fall risk:
Have you fallen within the last 3 months? ☐ Yes ☐ No

Do you use any ambulatory aids? ☐ Yes ☐ No
If yes, please check: ☐ Wheelchair ☐ Cane ☐ Walker ☐ Other_____

<u>Nutrition History:</u>

Height =_____ Weight = _____
Weight change during pregnancy: ☐ Gain ☐ Loss ☐ How much? _____