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Diabetes and Pregnancy Assessment Form

Please answer the questions by marking appropriate boxes or writing in accurate information in provided spaces. If you are unsure about how to answer a question, please give the best answer you can.

DEMOGRAPHIC INFORMATION Name: _____

Today's date: _____ What is your age? _____ What is your Gender? Female

What is your Race/Ethnicity? (mark all that apply)

- Black or African American
- American Indian or Alaska Native
- White or Caucasian
- Asian Indian
- Filipino
- Korean
- Guamanian or Chamorro
- Other _____
- Asian
- Native Hawaiian or Other Pacific Islander
- Middle Eastern
- Chinese
- Japanese
- Vietnamese
- Samoan

Are you Hispanic (Latino, Mexican, Spanish)? Yes No

Education (mark highest level completed)

- Elementary school
- Some college
- Some high school
- College degree
- High school degree
- Postgraduate

What is your Occupation? (mark only one)

- Clerical
- Skilled Labor
- Retired
- Homemaker
- Other Labor
- Other _____
- Sales
- Student
- Professional/Managerial
- Unemployed

Do you have any physical limitations? (mark all that apply)

- Hearing problems
- Problems with use of hands
- Vision loss (not corrected by glasses or contacts)

What is your primary language?

- English
- Spanish
- Other, please list: _____

HEALTH HISTORY

General Health Issues: (check all that apply and explain)

- high blood pressure
- heart disease
- high cholesterol
- thyroid disease
- kidney/bladder problems (explain) _____
- asthma
- shortness of breath (explain) _____
- eye or vision problems (explain) _____
- numbness/pain/tingling of hands/feet (explain) _____
- frequent nausea, vomiting, constipation, diarrhea _____
- other health problems _____
- list any surgeries in last 5 years _____

As health care providers, we are concerned about the safety of our patients so we ask every patient:

- Do you feel safe at home? No Yes
- Do you feel safe in your neighborhood? No Yes (If no, you may discuss this with the diabetes educator)



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WOMEN'S HEALTH:

Number of previous pregnancies: _____ Birth weight of infants: _____

Number of children: _____

Complications during previous pregnancies? no yes (explain): _____

Previous gestational diabetes no yes **treatment:** diet # calories _____ insulin _____

Concerns related to this pregnancy? no yes (explain): _____ twins triplets

Due date: _____ Weeks pregnant: _____ Frequency of obstetrician visits: _____

ACTIVITY DURING PREGNANCY:

What type of exercise do you do now? walk bike aerobic machine swim sports active job
 other _____

How often do you currently exercise? (*times/week*) 0 1-2 3-4 5-6 > 6

How long? (*minutes/day*) 0 1-15 16-30 31-45 46-60 >60

Has your doctor advised you to restrict your activities? no yes Explain: _____

NUTRITION:

Prepregnancy weight: _____

Usual time you get up _____ go to bed _____

Meal times: breakfast _____ lunch _____ dinner _____

a.m. snack _____ afternoon snack _____ p.m. snack _____

List typical foods eaten:

breakfast _____ snack _____

lunch _____ snack _____

dinner _____ snack _____

Do you drink alcohol? no yes Do you drink milk? daily weekly never

What specific eating concerns do you have? appetite heartburn vomiting diarrhea constipation

weight gain other _____

Food preferences: vegetarian _____ other _____

Food Allergies: _____

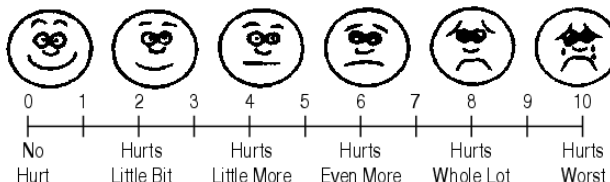
MEDICATIONS:

Drug allergies: No Yes (*please list*)

MEDICATION AND DOSE (include prescriptions, vitamins, herbals, and over the counter)	TIMES TAKEN	DATE STARTED
Prenatal vitamins <input type="checkbox"/> yes <input type="checkbox"/> no		
Calcium supplements <input type="checkbox"/> yes <input type="checkbox"/> no		

Do you have any pain because of your diabetes today? No Yes If Yes, where is the pain?

If yes, please rank your pain on a scale of:



List any medications or treatment you use to take care of the pain _____

Is your pain relieved with medication or other treatment? No Yes

PATIENT IDENTIFICATION

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How often do you need to have someone help you with instructions, pamphlets, or other written material from your doctor or pharmacy?

- never rarely sometimes often always

To help us focus on diabetes issues which concern you most, please identify any issues that are especially important to you:

- Eating healthfully and following my food plan Becoming and staying physically active
 Testing my blood sugar regularly Taking diabetes medication as prescribed, if any
 Balancing stress Seeking support when I need it
 Preventing complications Problem solving: dealing with challenges associated with diabetes

Others _____

Is it difficult for you to pay for diabetes care? no yes (explain) _____

Are you aware of diabetes community resources? no yes

If you developed diabetes during your pregnancy:

Sign here: _____ Date _____

If you had diabetes prior to your pregnancy, please continue:

DIABETES HEALTH STATUS

What year were you told you had diabetes? _____

Have you attended a diabetes education program? No Yes

What infections have you had within the last 3 months (mark all that apply)

- Head, throat, chest Wound Vaginal (yeast) Bladder None

Do you have family history of diabetes? No Yes

MONITORING:

Are you testing your blood sugars at home? no yes

Name of meter _____

How many days a week do you usually test? none 1-2 days/week 3-5 days/week daily occasionally

How many times a day do you usually test? 1-2 times/day 3-4 times/day daily

What blood sugar range do you try to achieve? _____

Do you have low blood sugar reactions? no yes symptoms _____

If so, what time of day? morning afternoon evening overnight varies

of times per week: 0 1-2 3-4 > 4

Do you carry a sugar source? no yes _____ (describe)

Do you wear diabetes identification? no yes _____ (describe)

What was the result of your last Hemoglobin A1C test? _____ % Date: _____ Unsure

Last foot exam _____ Pneumonia vaccine _____

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LIVING WITH DIABETES

a. Please tell us how you feel about your diabetes (mark one answer for each question)

	A Lot	Some	A Little	Not at All
How sure are you that you can manage your diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do you feel your family/friends support your efforts for diabetes control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does your medical team help with your diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does diabetes interfere with your job, school, or daily activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does your diabetes seem out of control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much are you afraid you will get complications?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel overwhelmed by your diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does your diabetes interfere with sexual function?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 2 weeks:

Have you often been bothered by feeling down, depressed, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you often been bothered by little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Participant Signature _____ Date _____

Educator Comments:

Date reviewed: _____ Educator Signature: _____

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