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

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<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Times Taken</th>
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Vaccines:    Flu (date: _______)   □T-Dap (date:_______)

Women’s Health
Number of: Previous: Pregnancies _____ Living children _____
Infant’s birth weight: __________________________________________

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 □ Testing my blood sugar regularly
□ Becoming and staying physically active □ Balancing stress
□ Taking diabetes medication if needed □ Seeking support when I need it
□ Others: ____________________________________________________________

(ID Label)
Living with Diabetes
Over the past 2 weeks, 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: __________________

Updated 11-22-2017