MUNSON HEALTHCARE
Diabetes Education

Gestational Diabetes Self-Assessment

General Information:

Name: _______________________________________ Birth Date: ____________ Date: ___________________

Name you would like to be called: ________________ Who lives with you? ____________________________

Phone: (Home) _________________ (Cell) _________________ (Work) _______________________________

Can we contact you at work? ☐ Yes ☐ No

Race: ☐ White ☐ Native American ☐ Hispanic ☐ African American ☐ Asian ☐ Other ___________________

Do you have any religious or cultural practices/beliefs that affect how you care for your diabetes?

☐ Yes ☐ No If yes, please explain ____

Social:

Are you currently employed? ☐ Yes ☐ No ☐ Student ☐ Disabled

Type of job and work hours? _____________________ Last grade of school completed _______________

How do you learn best? (Check **all** that apply)

☐ Reading ☐ Listening ☐ Seeing/Visual ☐ Doing ☐ Watching videos/TV ☐ Other ___________________

Check if any of these may affect your learning:

☐ Hard of Hearing ☐ Poor Vision ☐ Trouble Reading ☐ Memory Problems ☐ Learning Difficulty

☐ Do not speak English ☐ Other

Does your insurance cover all or part of: **(**Call insurance for this information)**

☐ Health care provider visit ☐ Supplies ☐ Gestational Diabetes Education

If you have no insurance, can you pay for these things? ☐ Yes ☐ No

Healthy Eating:

Height: _________ Weight: _________ Pre-pregnancy Weight: __________

How many meals do you eat daily? ☐ 1 ☐ 2 ☐ 3 How many snacks daily ☐ 1 ☐ 2 ☐ 3

What kind of snacks? ____

What beverages do you drink daily? ☐ Water ☐ Juice ☐ Pop ☐ Diet drinks ☐ Coffee ☐ Tea

How often do you eat out or bring home "take out"? ☐ Never ☐ Daily ☐ Weekly ☐ Monthly

Do you have chewing or swallowing problems? ☐ Yes ☐ No

Food allergies/What kind?____________________________ Can you afford your food? ☐ Yes ☐ No

List **All** medications: Include those needing a prescription and not needing a prescription.

For example: Over the counter - Aspirin, Motrin, Tylenol, Cough/Cold Medicines

Name of Medication	Amount/How Often?	What is it for?

List **All** supplements: Include vitamin, mineral, herbal, or dietary supplements.

Name of Supplement	Amount/How Often?	What is it for?

Medical History:

List any health problems: ____

____

Do you drink alcohol? ☐ Yes ☐ No If yes, what kind? ________________________________

How much do you usually drink? ☐ Daily ☐ 2-4 times/week ☐ Once a week ☐ Once a month

Do you smoke cigarettes? ☐ Yes ☐ No If yes, would you like information about quitting? ☐ Yes ☐ No

Gestational Diabetes History:

Due Date: _________________

Have you ever had gestational diabetes with a prior pregnancy? ☐ Yes ☐ No If yes, date? _____________

Have you ever had gestational diabetes education before? ☐ Yes ☐ No If yes, date? ___________________

Do you plan to have more children? ☐ Yes ☐ No ☐ Maybe

Being Active:

Do you exercise regularly? ☐ Yes ☐ No My exercise routine is: ☐ Easy ☐ Moderate ☐ Intense

Coping:

Do you feel safe in your home? ☐ Yes ☐ No

What is your current stress level?

Not stressed ----------------------------- Somewhat -------------------------------- Very stressed

1 2 3 4 5

How do you handle things that worry you? ____

What concerns do you have for you or your baby? ____

How interested are you in learning about gestational diabetes?

Not interested ----------------------------- Somewhat -------------------------------- Very interested

1 2 3 4 5

Please check all topics below that you would like to learn about		**Educator recommendation**	**Education plan agreed upon**
General explanation of gestational diabetes	☐	☐	☐
Healthy Eating	☐	☐	☐
High/Low blood sugar	☐	☐	☐
Monitoring	☐	☐	☐
Insulin therapy	☐	☐	☐
Other:	☐	☐	☐

Is there anything else you would like us to know?

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Educator comments (notes of clarification elsewhere are to be dated/initialed)

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Reviewed by: ______________________________________ Date/Time: _________________

Reviewed by: ______________________________________ Date/Time: _________________

Reviewed by: ______________________________________ Date/Time: _________________

Reviewed by: ______________________________________ Date/Time: _________________