Iowa Specialty Hospitals & Clinics
Specializing in You

Gestational Diabetes Education Patient Intake Form

Name: _____ Date of Birth: _____ Due Date: _____

Name you prefer to be called: _____ Todays Date: _____

Primary Care Provider: _____ OB Provider: _____

Lifestyle/Coping Questions:

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who else lives in household? _____

Do you work? ☐ No ☐ Yes: Type of work: _____ Work hours: _____

Race: _____ Primary Language: _____

Please list cultural/religious beliefs that may impact your care: _____

Do you ever fast? ☐ No ☐ Yes: Explain _____

Last grade completed: _____ Can you read English? ☐ Yes ☐ No Can you write English? ☐ Yes ☐ No

Do you have any barriers to receiving care? ☐ Housing ☐ Utilities ☐ Food ☐ Transportation ☐ ADLs
☐ Caregiver ☐ Support Network ☐ None of the above ☐ Other _____

Do you have any difficulty with: ☐ Physical difficulty ☐ Seeing ☐ Hearing ☐ Reading ☐ Writing
☐ English as a second language ☐ None of the above ☐ Other _____

How do you prefer to learn? ☐ Written materials ☐ Verbal Discussion ☐ Videos ☐ Other _____

Tobacco Use ☐ No, never ☐ Previously, total years _____ Quit date _____
☐ Yes: Type _____ Amount _____
Interest in quitting? ☐ Yes ☐ No

Alcohol Use ☐ No ☐ Yes: Type _____ Amount _____

Recreational Drug Use ☐ No ☐ Yes: Type _____ Amount _____

Do you experience pain that affects your lifestyle? ☐ No ☐ Yes: Explain _____

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Diabetes and Support Questions:

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Prediabetes
☐ LADA ☐ MODY ☐ Do not know

Have you had a hospital admission due to diabetes in the past 12 months? ☐ Yes ☐ No

If yes: Number of hospital admissions due to diabetes in the past 12 month: _____

Total number of days due to diabetes in the last year: _____

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Visited primary doctor or endo or diabetes educator within 7-14 days after discharge: ☐ Yes ☐ No

Reason for hospital admissions due to diabetes: _____

Who else in your family has diabetes/has had gestational diabetes? ☐ None ☐ Mother ☐ Father

☐ Sibling(s): _____ ☐ Maternal Grandparent ☐ Paternal Grandparent ☐ Other_____

Is this your first pregnancy? ☐ Yes ☐ No: How many? _____ Children(s) birth weights: _____

Have you been diagnosed with depression? ☐ Yes ☐ No

Have you had little interest or pleasure in doing things:

☐ Not at all (0) ☐ Several Days (1) ☐ More than Half the Days (2) ☐ Nearly Every Day (3)

Experiencing feeling down, depressed or hopeless:

☐ Not at all (0) ☐ Several Days (1) ☐ More than Half the Days (2) ☐ Nearly Every Day (3)

Who is your primary support person? _____ Relationship to you _____

Blood Glucose Testing:

☐ I do *not* have a blood sugar monitor (glucometer) ☐ I use a CGM (continuous glucose monitor)

☐ I do have a blood sugar monitor (glucometer) Name of glucometer/CGM _____

When do you test your blood sugars?

☐ Before breakfast after waking up; Ranges _____

☐ Before meals; _____ minutes before meals; Ranges _____

☐ After meals; _____ hours after meals; Ranges _____

☐ Before bedtime; Ranges _____

☐ Other; Explain _____

What are your blood sugar goal ranges? _____

Diabetes Treatment:

Diabetes Medication(s): ☐ No Diabetes Medications

☐ Pill(s): Please list, including name, dosage, frequency _____

☐ Non-Insulin Injectables(s): Please list, including name, dosage, frequency _____

☐ Insulin(s): ☐ insulin vial/syringe ☐ insulin pen ☐ insulin pump

If you are using insulin, please list:			*If you are using Insulin Pump:*	
Name/Type of Insulin	# of Units	Time Taken	Insulin to Carb Ratio	
			Correction Factor (Insulin Sensitivity)	
			Target Blood Sugar	
			Make/Model of Pump	

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Nutrition Information

Current Height: _____ Current Weight: _____ Pre-Pregnancy Weight: _____

Who shops for food? ☐ Self ☐ Other: _____ Who prepares meals? ☐ Self ☐ Other: _____

What types of food do you like to enjoy for

Breakfast _____

Lunch _____

Supper _____

Snacks _____

How frequently do you eat out? ☐ 1-2 times/month ☐ 1-2 times/week ☐ 3-4 times/week ☐ Daily

Favorite restaurants/fast food places _____

Food allergies/restrictions/GI issues _____

What is your biggest challenge to eating healthy? _____

Are you confident in reading a nutrition facts label? ☐ No ☐ Yes ☐ Would like a review

How confident are you in making healthy choices? ☐ Not at all ☐ Somewhat ☐ Confident ☐ Very

In the past 12 months, were there times when it was difficult to buy enough groceries? ☐ Yes ☐ No

Do you use any of the following food assistance programs: Would you like more info? ☐ Yes ☐ No

☐ WIC ☐ Food Stamps ☐ Meals on Wheels ☐ Food Pantry ☐ Community Meals

Being Active

What physical activity do you do regularly? _____

How many minutes per session? _____ Days per week? _____

What, if any, barriers do you have to physical activity? _____

Today's Appointment

What questions/concerns do you have today? What would you like to learn about regarding your health?

☐ About gestational diabetes and treatment options ☐ Complications of gestational diabetes

☐ Lab interpretation/goals ☐ Healthy eating ☐ Being Active ☐ Medications ☐ Monitoring glucose

☐ Lifestyle and healthy coping ☐ Other _____

What are your goals for today's appointment? _____

Is there anything else you would like your diabetes educator to know? _____

_____

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Knowledge Assessment:

Directions: Read each question and decide which choice best completes the statement or answers the question.

1. I should be avoiding all types of carbohydrates in my diet to control my blood sugar
   - ☐ True
   - ☐ False
2. Which food groups contain carbohydrates: (check all that apply)
   - ☐ Dairy
   - ☐ Fruit
   - ☐ Vegetables
   - ☐ Grain/Starch
   - ☐ Protein
3. I should be screened for type 2 diabetes every year after my pregnancy
   - ☐ True
   - ☐ False
4. Some women with gestational diabetes will need insulin to keep their blood sugar in the recommended ranges?
   - ☐ True
   - ☐ False
5. I have a reduced risk for developing type 2 diabetes after my pregnancy
   - ☐ True
   - ☐ False
6. Eating for better health includes all of the following *except*:
   - ◯ A. Eating fruits and vegetables
   - ◯ B. Avoiding all foods with carbs
   - ◯ C. Being aware of portion sizes and choosing appropriate amounts of foods
   - ◯ D. Eating when hungry and stopping when satisfied
   - ◯ E. I do not know
7. I will need to test my blood sugar with a home monitor each day to make sure my blood sugar stays in a safe place
   - ☐ True
   - ☐ False
8. Which of the following is a way to practice eating mindfully?
   - ◯ A. Take 15-30 minutes to eat slowly and enjoy your food
   - ◯ B. Eat at a table
   - ◯ C. Use a hunger scale to help guide you when you eat and when to stop
   - ◯ D. All of the above
   - ◯ E. I do not know
9. How does physical activity usually affect your glucose level?
   - ◯ A. Lowers your glucose level
   - ◯ B. Raises your glucose level
   - ◯ C. Has little effect on your glucose level
   - ◯ D. None of the above
   - ◯ E. I do not know
10. Symptoms of low glucose include:
    - ◯ A. Feeling shaky or sweaty
    - ◯ B. Dry skin
    - ◯ C. Feeling energetic
    - ◯ D. Dry mouth
    - ◯ E. I do not know
11. Treatment for low glucose is
    - ◯ A. ½ cup orange juice
    - ◯ B. 1 can regular soft drink
    - ◯ C. 1 full-size candy bar
    - ◯ D. 1 ounce peanuts
    - ◯ E. I do not know
12. Illness and emotional stress generally cause your glucose level to:
    - ◯ A. Rise
    - ◯ B. Fall
    - ◯ C. Stay the same
    - ◯ D. None of the above
    - ◯ E. I do not know
13. Preconception care and planning is very important for future pregnancies
    - ☐ True
    - ☐ False

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