Diabetes Control Center

Diabetes and Pregnancy Assessment Form

Name: _____ Age: _____ D.O.B._____

Preferred Language _____ Referring Physician? _____

Blood sugar result today? _____ What is the name of your glucometer?_____

Do you use computers to search for health information or for e-mail? ☐ Yes ☐ No

How do you prefer to communicate? ☐ Verbal ☐ Written ☐ Other _____

Do you use any of the following? ☐ Contacts ☐ Eye glasses ☐ Hearing aids ☐ Other _____

Why are you here today? _____

What does diabetes and pregnancy mean to you? _____

Date of Diagnosis?_____ ☐ Type 1 ☐ Type2 ☐ Gestational diabetes

Have you had gestational diabetes previously? ☐ Yes ☐ No If yes, when_____

Have you had any diabetes education previously? ☐ Yes ☐ No ☐ If yes, _____

How many people live in your home? _____ How are they related to you?_____

Who do you rely on?_____

Highest education level? ☐ Grade school ☐ High school ☐ College ☐ Post graduate ☐ Skills trade

What is your exercise routine? Type_____ How long?_____ Times per week?_____

What is your occupation? _____ Days of the week work? _____ Shift/hours: _____

My stress level is: ☐ Low ☐ Moderate ☐ High

My stress factors are: ☐Financial/money ☐Job ☐Health ☐Personal/home ☐Other_____

Within the past 12 months we worried whether our food would run out before we had money to buy more?
☐ Often true ☐ Sometimes true ☐ Never true

Within the past 12 months the food we bought just didn't last and we didn't have money to get more?
☐ Often true ☐ Sometimes true ☐ Never true

Previous diets? _____ Who does food shopping? _____ Who does cooking? _____

Do you have any Religious/Spiritual or Cultural/Ethnic practices or beliefs related to your healthcare? _____

Number of times you eat out each week? _____ Places you eat out most? _____

Height:_____ = _____cm Weight: _____lb _____kg Pre pregnancy weight:_____lb _____kg

Due Date:_____ Weeks of Gestation:_____ Are you pregnant with twins or triplets? ☐ Yes ☐ No

Patient Label

DCCPAS

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Are you experiencing pain? ☐ Yes ☐ No Location?_____ Intensity (0-10)? ___ Describe:_____

Describe your pain_____ Is your pain managed by your doctor? ☐ Yes ☐ No

Have you fallen in the last 3 months? ☐ Yes ☐ No Ever have dizziness or vertigo? ☐ Yes ☐ No

Ever wet or soil yourself on the way to the bathroom? ☐ Yes ☐ No

Other than diabetes, list your past health history or surgical history? _____

Ever used tobacco? ☐ No ☐ Yes Year quit?_____ Type? ☐ Cigarettes ☐ Cigars ☐ Vaping How many per day? _____

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week _____ ☐ Type_____

Do you feel safe at home? ☐ Yes ☐ No Alcohol use past or present? ☐ Yes ☐ No

Do any family members have diabetes? ☐ Yes who? _____ ☐ No

Have you received a COVID vaccine? ☐ Yes ☐ No ☐ Prefer not to say ☐ Pfizer ☐ Moderna ☐ J&J ☐ Unsure

Are you fully vaccinated? ☐ Yes ☐ No ☐ Received booster? ☐ Yes ☐ No

Have you had your flu vaccine in the past 12 months? ☐ Yes ☐ No

Including this pregnancy, how many times have you been pregnant?_____

How many live births did you have? _____

Did any of your babies weigh more than 8 pounds? ☐ Yes ☐ No

Do you plan on breastfeeding? ☐ Yes ☐ No

In the boxes below, please write the times you eat and what you eat and drink for meals/snacks

Breakfast **Time:**	Snack **Time:**	Lunch **Time:**	Snack **Time:**	Supper **Time:**	Before Bed Snack **Time:**