UW Medicine
VALLEY
MEDICAL CENTER

Diabetes Education & Nutrition Clinic

Gestational Diabetes Assessment Form

Name: _____ **Date:** _____

Date of Birth: _____ **When is your baby due?** _____

We will need to let your doctor know which blood glucose monitor we provided you. Your doctor will call the prescription to your pharmacy. Please provide the name and phone number of the pharmacy where you would like to pick up your testing supplies: _____

Are you taking any medications related to diabetes? If so, please list: _____

_____

Do you have a family history of diabetes? ☐ Yes ☐ No

If yes, who in your family has diabetes? _____

Have you had other pregnancies? ☐ Yes ☐ No

If yes, how many, and what were their birth weights: _____

What is your main concern about managing Gestational Diabetes? _____

_____

Do you have any physical limitations or conditions (vision, physical, difficulty hearing) that may affect your ability to learn how to manage your diabetes? ☐ Yes ☐ No

If yes, please describe: _____

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

If yes to either, how much and how often? _____

Do you have any cultural or religious concerns over managing your gestational diabetes (examples: times of fasting, traditional foods)? ☐ Yes ☐ No

If yes please describe: _____

Last grade completed in school: _____

Who will be your primary emotional support person in dealing with Gestational Diabetes? _____

_____

Height/Weight:

Height: _____ Current Weight: _____ Pre-Pregnancy Weight: _____ Your best non-pregnant weight? _____

Nutrition:

Do you take an active role in food shopping and preparation? ☐ Yes ☐ No

How many meals per week do you eat out? _____ Where: _____

What is your main concern about your diet? _____

Rate the overall quality of your diet on the scale below

1	2	3	4	5
High fat, high sodium, high sugar intake				High fruits, vegetables, whole grains, lean meats

Exercise:

Do you exercise? ☐ Yes ☐ No If yes, what form(s) of exercise? _____

How many days per week? _____ How many minutes on these days? _____

If you are not yet active, what do you consider your main challenge in getting physical activity incorporated into your daily schedule? _____

Pre Class Knowledge Assessment

Please answer the following to the best of your ability. This information is for your educator to assess your personal learning needs and knowledge about gestational diabetes prior to your education.

1. Which of the following foods contain carbohydrates (check all that apply):
   ☐ Cheese ☐ Milk ☐ Apple ☐ Rice ☐ Peanut Butter ☐ Chicken ☐ Graham crackers ☐ Watermelon
2. Physical activity typically will lower blood sugar. ☐ True ☐ False
3. Some women with gestational diabetes will need insulin to keep their blood sugar in the recommended targets. ☐ True ☐ False
4. I have a reduced risk for developing type 2 diabetes after my pregnancy. ☐ True ☐ False
5. I should be avoiding all types of carbohydrates in my diet to control my blood sugar during my pregnancy. ☐ True ☐ False
6. I should be screened for type 2 diabetes every year after my pregnancy. ☐ True ☐ False
7. I will need to test my blood sugar with a home monitor each day to make sure my blood sugar stays in target. ☐ True ☐ False
8. Preconception care and planning is very important for future pregnancies. ☐ True ☐ False

For Staff Use:

Education and follow-up plan: (based on individual interview and medical history form)

☐ Patient appropriate for group education ☐ Patient best served with individual education

☐ Other: _____

Outcomes Evaluation: All participants contacted six months after education with follow-up survey.

Patient attended last class in series or scheduled individual follow up? ☐ Yes ☐ No *(If no, then educator unable to evaluate)*

Self management goals meet most of the time? ☐ Yes ☐ No

Comments: _____

_____

_____

_____ _____

Diabetes Educator Signature Date