Diabetes Learning Center
Edward - Elmhurst Health
1200 S. York, Elmhurst, IL 331-221-6440 Ext. 3
Gestational Diabetes Assessment

Name _____ DOB _____ Date _____

Primary Language Spoken _____ Phone _____ Due date _____

Occupation _____ Employer _____

Ethnicity _____

Last Grade of Education Completed: _____

Primary Support Person(s) _____Relationship _____

Preferred pharmacy _____

Did you have a 3-hour glucose tolerance test? Yes or No?

Do you have any difficulties with hearing, reading, seeing, speaking or psychological concerns? If yes, which?

_____

In your own words, what is gestational diabetes? _____

How do you best learn? (Place check mark by item) ___ Hearing ____ Reading ___ Seeing ____ Doing

What would you like to learn today regarding gestational diabetes? (Place checkmark by item) Eating ___

Physical Activity ___ Checking Sugars ___ Taking Medications ____ Preventing Complications ____ Behavior

Changes Strategies ___ Healthy Coping _____

Do you have any difficulty affording your current medications? _____

HEALTH HISTORY

- Have you had gestational diabetes in the past? Yes No If Yes, When _____
- Number of previous pregnancies _____ Number of living children _____
- Any complications during this pregnancy? _____
- Do you have any relatives that have diabetes? Yes No Who? _____
- Do you smoke cigarettes, vape, use marijuana or CBD? Yes No
- Do you exercise regularly? Yes No
  Type _____ # Minutes _____ Frequency _____
- If you are not exercising, what is preventing you? _____
- Do you get enough rest at night? Yes No
- Do you check your blood sugar and/or have you ever checked your blood sugar? _____
- Please write agree, disagree or unsure in response to the following: I have some control over whether I develop complications related to gestational diabetes? _____
- Do you have any cultural or religious preferences that may influence how you care for your diabetes?
  _____

- Do you feel that you have a good outlet or way manage stress? Yes No

NUTRITION HISTORY

- Height_____ Weight_____ Weight before pregnancy_____
- Do you feel that it will be difficult to make healthy food choices? Do you have any concerns about the way you eat now? (explain)
  _____
  _____
- Do you follow any special diet (vegetarian, diet for celiac disease, WW, etc.)? _____
- Is purchasing healthy foods a financial hardship for you? Yes No
- Are you currently drinking any alcohol? Yes No
- Do you drink caffeinated coffee/tea/cola? Yes No Type/Amount/How Often? _____
- Do you use artificial sweeteners? Yes No Type/Amount/How Often? _____
- Do you eat any meals away from home, such as fast foods, cafeterias, buffet, or other restaurants? If yes, which meals and how often?
  Breakfast: _____ x weekly Lunch: _____ x weekly Dinner: _____ x weekly
- Are you experiencing any of the following?
  Nausea _____ Vomiting _____ Heartburn _____ Constipation _____
- Do you drink regular sweetened pop or beverages? How often? _____
- Do you drink fruit juice? How often? _____
- Do you eat sweets such as candy, ice cream, pudding, cookies, pie, cake, pastries, etc? Which and how often? _____

List typical Menu for a Day
(Food and Portion Size)

Weekdays / Work Days	Weekends / Days Off
1st meal	1st meal
Snack	Snack
2nd meal	2nd meal
Snack	Snack
3rd meal	3rd meal
Snack	Snack