Diabetes and Endocrinology
1919 Lincoln Way, Suite 211
Coeur d'Alene, ID 83814

NEW GESTATIONAL DIABETES EDUCATION PATIENT INFORMATION

Patient Name: _____ ***Date of Birth:*** _____

When were you diagnosed with diabetes? Age_____ or Year_____ New diagnosis?_____

Blood Glucose (sugar) Testing History

Are you currently testing your blood glucose? ❑ Yes ❑ No	If Yes, how often and what time of day do you test?	What type of glucometer do you use?

Hypoglycemia (low blood sugar) and Sick Day Plan

Have you had any hypoglycemic episodes in the past 2-3 weeks? • If yes, how many episodes have you had?_____	**Yes**	**No**
Do you have hypoglycemia episodes that you can't feel?		
Do you carry food to treat hypoglycemia episodes?		
Do you wear a medical ID?		
Have you required assistance from others to treat your lows?		
Do you have a glucagon emergency kit?		
Do you always check your blood sugar before you drive?		
• Have you ever had a low blood sugar while driving?		
Do you have a sick day plan?		
Do you have ketone test strips at home?		

Social/Lifestyle/Quality of Life

***Employment* factors you have that might impact your diabetes self-care (Check all that apply)**

- ❑ Night Shift
- ❑ Variable/Rotating Shifts
- ❑ Unpredictable Meal Breaks
- ❑ Unsupportive supervisor
- ❑ Unpredictable activity level
- ❑ Frequent Travel
- ❑ Multiple meetings/catered meals
- ❑ Sedentary job
- ❑ High stress job
- ❑ Nowhere to keep diabetes testing/medication supplies
- ❑ Don't want co-workers to know about my diabetes
- ❑ Other: _____

Other factors that might impact your diabetes self-care

- ❑ None
- ❑ Family or relationship conflicts
- ❑ Hectic schedule
- ❑ Lack of Motivation
- ❑ Other health issues
- ❑ Financial Concerns
- ❑ Diabetes Burnout
- ❑ Diabetes Regimen too complicated
- ❑ Confusion about my diabetes regimen
- ❑ Other:_____

Have you had diabetes education in the past?

- ❑ No
- ❑ Yes

If yes, when and where?

How do you like to learn new things? (check all that apply)

- ❑ Reading
- ❑ Lectures/Classes
- ❑ Using the Internet
- ❑ Watching Videos/ TV
- ❑ One-on-one teaching/ demonstrations

Pregnancy, Nutrition, Activity, Medical History

Current Height: _____ Current Weight: _____ Pre-pregnancy weight: _____ Due Date: _____

Number of Pregnancies:	**Number of Live Births:**	**Prior Gestational Diabetes?** ❑ Yes ❑ No	**If Yes, size of baby:** _____lb ____oz	**If Yes, did you require insulin?** ❑ Yes ❑ No ❑ Took oral meds

Complications this pregnancy: ❑ Hyperemesis ❑ High Blood Pressure ❑ Spotting/bleeding ❑ Other	**Prenatal Vitamins:** ❑ Yes ❑ No	**Other Meds:**

What food planning methods have you followed in the past?

What method of food planning are you using now?	**How many times per week do you eat out? (including beverages)** ❑ **0-1** ❑ **2-3** ❑ **>4**

What times of day do you typically eat?

What kind of foods do you typically choose as snack foods?

How often do you drink juice?
- ❑ One or more a day
- ❑ Few times a week
- ❑ Less than once a week
- ❑ Never

How often do you drink Regular Soda?
- ❑ One or more a day
- ❑ Few times a week
- ❑ Less than once a week
- ❑ Never

How often do you drink Alcohol?
- ❑ One or more a day
- ❑ Few times a week
- ❑ Less than once a week
- ❑ Never

Do you have any other relevant medical conditions? ❑ Yes ❑ No **Please list**: _____

Do you get deliberate and regular exercise? ❑ Yes ❑ No **How often and what type**?_____

Do you take any diabetes medications? ❑ Yes ❑ No **Please list:** _____

What is your preferred Pharmacy?

Educator notes: