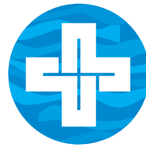
Guadalupe Regional
MEDICAL CENTER
Advanced Medicine. Personal Touch.



Gestational Diabetes Registration Form

Class Date: ____________ Assessment Date: ____________

GESTATIONAL DIABETES PROGRAM PARTICIPANT INFORMATION SHEET

Name:		**Date of Birth:**	
Address:	**City:**	**State:**	**Zip Code:**
County:	**Email:**		
Phone Number Home:	**Work:**	**Cell:**	

Language: ❑ English ❑ Spanish ❑ Other: ____________

Present Employment: ____________ **Occupation:** ____________

At work, I am primarily: ❑ Sitting at a Desk ❑ Standing ❑ Walking ❑ Very Active ❑ I Do Not Work

Have you lost any days of work due to diabetes? ❑ Yes ❑ No

What level of education have you completed? ❑ No High School ❑ GED ❑ High School ❑ Associates ❑ Bachelors ❑ Graduate Degree

Do you have: ❑ Visual Problems ❑ Hearing Problems ❑ Reading Problems ❑ Problems with Understanding English

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Race/Ethnicity: ❑ White ❑ Hispanic ❑ African American ❑ Asian/Pacific Islander ❑ Other: ____________

Referring Physician: ____________ **and/or Clinic:** ____________

Insurance Provider: ❑ Private Insurance ____________ ❑ Medicare ❑ Medicaid ❑ Other Indigent Program ❑ No Insurance

Health History:

What is your expected delivery date (due date)? ____________ **Weeks gestation:** ____________

Number of pregnancies: ____________ **Number of living children:** ____________

Did you have gestational diabetes in previous pregnancies? ❑ Yes ❑ No

If yes, any problems with the infant? ❑ Yes ❑ No

Are you planning to breastfeed your baby? ❑ Yes ❑ No

I have: ❑ Polycystic Ovarian Syndrome ❑ Diabetes ❑ Heart Disease ❑ Cancer ❑ High Blood Pressure ❑ Migraines ❑ Seizures ❑ Kidney Disease ❑ Kidney Problems ❑ Sexual Problems ❑ High Cholesterol ❑ Difficulty Seeing ❑ Asthma ❑ Depression ❑ Stroke ❑ Numbness/tingling in feet ______ or hands ______ ❑ Thyroid Disease ❑ Other: ____________

How do you currently manage your diabetes? Please mark all that apply: ❑ Meal Plan ❑ Pills ❑ Exercise ❑ Insulin ❑ Self-blood Glucose Monitoring ❑ Healthy Coping

Do you own a home glucose meter? ❑ Yes ❑ No ❑ **Brand:** ____________

Have you tested for ketones? ❑ Yes ❑ No

Family History: My parent, grand parent or brother or sister has or had: ❑ Diabetes ❑ Heart Disease ❑ Cancer ❑ High Blood Pressure

Do you smoke? ❑ Yes ❑ No How long have you smoked? ______ Number of packs smoked per day ______

Do you drink alcohol? ❑ Yes ❑ No How many drinks do you drink a week? ______

Do you use recreational drugs? ❑ Yes ❑ No What kind and how often? ____________

Do you have any problems with nausea and vomiting? ❑ Yes ❑ No

How do you learn best? ❑ Lecture/discussion ❑ Demonstration ❑ Film/TV ❑ Reading ❑ Hands-on

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Nutrition

Please describe your daily foods eaten and schedule:

Breakfast: ______________________ Time: ________ Lunch: ______________________ Time: ________

Dinner: ______________________ Time: ________ Snacks/times: ______________________

Nutritional History

Height: ________ Current Weight: ________ Pre-Pregnancy Weight? ________

Have you had recent weight change? ❑ Yes ❑ No ❑ Gained ❑ Lost How much? ________

Do you have a history or any of the following problems? ❑ Food allergies ❑ Frequent diarrhea ❑ Constipation ❑ Reflux ❑ Trouble chewing ❑ Eating disorder Other: ______________________

Have you ever been on a special diet? ❑ Yes ❑ No If yes, what type? ______________________

Who cooks? ______________________ Who grocery shops? ______________________

How many times a week do you eat away from home? ______________________

Physical Activity

How many times do you exercise per week? ______ times ______ minutes What type of exercise do you do? ______________________

Is there a particular reason you cannot exercise? If so, list: ______________________

Medication

Please list all your Medications including over the counter meds or provide a list of your medications

Medication Name	Dose/Time(s) Taken	Medication Name	Dose/Time(s) Taken

How many days out of the week do you remember to take your medication? ______________________

Are you allergic to any medications? ❑ Yes ❑ No If yes, please describe: ______________________

Do you wear an insulin pump? ❑ Yes ❑ No

Psychosocial

How would you rate your current understanding of gestational diabetes? ❑ Good ❑ Fair ❑ Poor

Which best describes how you feel about diabetes? ❑ Frustrated ❑ Angry ❑ Guilty ❑ Other: ______________________

What is the hardest thing for you when dealing with diabetes? ______________________

____

What health behaviors do you think you need to start changing (ex. Food choices, healthy coping)? ______________________

____

Is there anything about your culture/religion that could affect how you manage your diabetes/meal plan? ❑ Yes ❑ No

If yes, please describe: ______________________

Who helps you with your diabetes care? ______________________

Emotional Health

How do you cope with stress? ______________________

Who is your emotional support? ______________________