3PA

GESTATIONAL HEALTH SURVEY
General Information

Name:_____ Date: _____

Birth date: _____ Age:_____ Best phone number_____ Best time to call _____

What is your preferred language? _____ spoken _____ written

Primary Care Doctor:_____ Diabetes Doctor: _____

How would you describe your health? _____

Knowledge of Diabetes

In your own words, what is gestational diabetes?

Pregnancy History

How many times have you been pregnant? _____ Miscarriages? _____ Abortions? _____

Expected date of delivery _____ Confirmed by ultrasound? ☐ Yes ☐ No

Did you have gestational diabetes in the past? ☐ Yes ☐ No

Did you have pregnancy complications in the past? ☐ Yes ☐ No Explain: _____

Medications

Please list the names of **ALL** medications **(Bring medications to appointment)**

Name	Dosage	When Taken

Do you take prenatal vitamins? ☐ Yes ☐ No Name: _____

Are you allergic to any medications? ☐ Yes ☐ No Explain: _____

Others:

Medical History

What other conditions do you have? Explain: _____

_____

Last eye exam? _____ Last dental checkup? _____

List major operations you've had: _____

Do you smoke cigarettes? ☐ Yes ☐ No If yes, number of cigarettes each day? _____

Are you exposed to second-hand smoke? ☐ Yes ☐ No _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Do you use illicit drugs? ☐ Yes ☐ No If yes, explain _____

11483 ODE 1595 (9/30/08)

PATIENT LABEL

Washington Hospital Healthcare System
Washington Township Healthcare District
2000 Mowry Avenue, Fremont, California 94538-1716 • (510) 797-1111

GESTATIONAL DIABETES PATIENT SELF-ASSESSMENT

Nutrition

Do you follow any diet or fluid restrictions? ☐ Yes ☐ No Explain:_____

Do you have a history of an eating disorder? ☐ Yes ☐ No (describe): _____

List any food allergies or intolerances _____

List any cultural / religious diet restrictions you follow, if any _____

Are you having any problems with heartburn? ☐ Yes ☐ No _____ Constipation? ☐ Yes ☐ No

How would you describe your appetite? ☐ Good ☐ Poor ☐ Excessive (large portions)

Diet History (what foods do you usually eat)

Breakfast	Lunch	Dinner

Snacks:

Exercise

Have you been advised to limit exercise? ☐ Yes ☐ No (describe) _____

Do you exercise on a regular basis? ☐ Yes ☐ No Type _____

How many times a week do you exercise?_____ For how long? _____ minutes

Monitoring

Do you test your blood sugar? ☐ No ☐ Yes If yes, what meter do you use? _____

Social History

How do you learn best? ☐ Reading ☐ Demonstration ☐ Hands on ☐ Watching TV

Tell us anything you feel may interfere with your ability to learn:_____

Do you have difficulty with? ☐ Hearing ☐ Speech ☐ Vision Explain: _____

Marital Status: ☐ Single ☐ Married ☐ Significant Other ☐ Divorced ☐ Widowed

Last Grade in School?_____ Number in Household?_____

(Optional) Race_____ (for data collection purposes only)

Do you work? ☐ Yes ☐ No If yes, type of work?_____ Work hours?_____

Is there anything else you would like us to know about you? _____

Your expectations of our Diabetes Program _____

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