Novant Health UVA Health System Prince William Medical Center Diabetes Services

Name: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Weeks Pregnant: _____ Due Date: _____ Height: _____

Weight: _____ Pre-Pregnancy Weight: _____ Last Menstrual Period: _____

Number of times you have been pregnant counting this pregnancy: _____ Number of children born alive: _____

Are you expecting: ☐ Single ☐ Twins ☐ Triplets

Are you currently breastfeeding? YES NO

Do you have any episodes of nausea or vomiting? YES NO

Do you have: History of diabetes with previous pregnancies? YES NO

History of high-risk pregnancies? YES NO

If yes, please explain: _____

Family history of diabetes? YES NO

If so, who? _____

Medications: _____

_____

Health problems: _____

_____

Are you currently testing your blood sugar? YES NO

If so, when? _____

Type of meter? _____

Usual reading? _____

Are you presently following a meal plan? YES NO

If so, what? _____

Do you have food allergies? YES NO

If so, please list: _____

Do you take vitamins? YES NO

If so, please list: _____

Do you smoke? YES NO

If yes, how much? _____

Do you drink alcohol? YES NO

If yes, how much? _____

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Do you drink coffee, tea or soda? YES NO

If yes, describe? _____

Do you have any cultural or food preferences? YES NO

If yes, explain: _____

Do you salt your food? YES NO

How often do you eat out? _____

Who does the grocery shopping in your household? _____ Cooking? _____

What time do you eat: Breakfast _____ Lunch _____ Dinner _____

Would you classify your appetite as? Good _____ Fair _____ Poor _____

Do you exercise regularly? YES NO If yes, how often? _____

Has your OB provider told you to restrict your activities? YES NO

Number in household? _____ Current major stress? _____

Primary support person? _____ Present employment? _____

Number of years in school? _____ Financial concerns? _____

Country of origin? _____

How do you learn best? ☐ By listening ☐ By looking/observing ☐ By demonstration

Do you have difficulty with? Vision YES NO

Hearing YES NO

Reading/Writing English YES NO

What concerns you most about diabetes? _____

I give my consent for finger/arm sticks to be done to test blood glucose and for the educator to contact my physician with any concerns and progress.

I release Novant Health UVA Health System Prince William Medical Center, The Wellness Center and the Diabetes Educator(s) from any and all liability arising from or connected with the finger/arm stick or education process.

Signature/Name _____ Date/Time _____

Reviewed by (Name/Credentials) _____ Date/Time _____