**Gestational Diabetes Questionnaire**

Patient Name: _____ Age: _____ Date of Birth: _____
Who is with you today? _____

Do you have any medical problems? _____

_____

When is your baby due? _____
Number of pregnancies you have had (including this one)? _____
Number of children you now have: _____
Number of miscarriages/abortions you have had: _____
Have you had gestational diabetes in a previous pregnancy? ☐ Yes ☐ No ☐ Not applicable

What medications are you now on? (include vitamins/minerals supplements, herbs) _____
Family history of diabetes? ☐ Yes ☐ No If yes, who? _____
Your height: _____ Pre-Pregnancy weight: Present weight:

Occupation: _____ Hours worked per week: _____
When do you go in to work? _____ When do you get off? _____
What time do you get up? _____ What time do you go to bed? _____
Education level: _____
Any cultural/ethnic/religious influences we need to know about? _____

Are you a vegetarian? _____ Vegan? _____
Any major life stresses? _____

_____

Who do you live with? _____ Number of people in household: _____
Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Who cooks? _____ Who shops? _____
Any food assistance used? _____
How is your appetite? ☐ Poor ☐ Fair ☐ Good
Use any tobacco? _____ Alcohol? _____ Recreational Drugs? _____
Do you have any food cravings? _____
Do you have any food aversions?
Do you have any desire to eat non-food items? _____
Any food allergies or intolerances? _____
How do you plan to feed the baby? ☐ Breastfeeding ☐ Formula feeding ☐ Combination ☐ Unsure

What pharmacy do you use? _____

NOVANT HEALTH

**Gestational Diabetes Questionnaire**

806235 R 04/02/2020

Patient Name: _____
DOB: _____
(or use patient label)
Name / MR # / Label

## Diabetes Psychosocial

Over the past two weeks how often have you been bothered by any of the following problems:

| | | | | |
|---|---|---|---|---|
| Little interest or pleasure in doing things | Not at all | Several days | More than half the days | Nearly every day |
| Feeling down, depressed or hopeless | Not at all | Several days | More than half the days | Nearly every day |

1. Do you have financial concerns regarding the following: (Check all which apply)
   ☐ Diabetes Supplies ☐ Housing ☐ Food ☐ Utilities ☐ Medications ☐ None

   Do you have prescription coverage? ☐ Yes ☐ No

   Please note: If you have prescription coverage for medications, most of the time you are ineligible for any form of financial assistance.

2. Do you require assistance cooking meals, cleaning house, or taking care of personal needs such as bathing and dressing? ☐ Yes ☐ No

3. Have you experienced a loss in appetite, difficulty sleeping, or inability to function normally throughout the day? ☐ Yes ☐ No

4. Are you and/or your family having a difficult time coping with your diabetes? ☐ Yes ☐ No

5. Would you like to speak with a social worker about services available to assist with the needs as identified above? ☐ Yes ☐ No

If yes, please provide a current phone number and most convenient time of the day a social worker can contact you. If you work during the day, please indicate if you can accept calls at place of employment and provide a contact number. Social workers are available Monday through Friday, 8 am to 5 pm.

Name: _____

Phone number: Home: _____ Work (if applicable): _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)