St. Francis Hospital
DIABETES TREATMENT

Gestational Diabetes Class Assessment

(Please complete front and back of this form)

Date_____

Demographics:

Name:_____ Preferred Name:_____ Date of birth:_____
Primary Language: □English □Spanish □French □Other:_____
Race/Ethnicity: □Black □African American □American Indian or Alaskan Native □Hispanic
□Middle Eastern □Asian/Pacific Islander □White/Caucasian □Other:_____
Please list cultural or religious beliefs that may impact your care:_____
Marital Status: □Married □Single □Divorced □Widowed
What do you do for work?_____ Work Hours:_____
Who lives with you? _____
Who is your main support person? _____
What is the last grade you completed in school? _____
Do you have any learning disabilities (such as dyslexia) or problems with vision, hearing, or reading? Please explain:_____
How do you prefer to learn? □Listening □Reading □Demonstration □Doing □Group Session
□No learning preference □Other:_____

General Health:

Height:_____ Current Weight:_____ Pre-pregnancy weight:_____
Any changes noted in weight before pregnancy? _____
How many weeks gestation are you today? _____
Have you had Gestational Diabetes with a previous pregnancy? _____
If so, when and what treatment was used? _____
Health conditions other than gestational diabetes:_____
_____
Do you check blood sugars at home? □Yes □No How many times a day? _____
When do you check your blood sugar? □Fasting/Before Breakfast □After Breakfast □After Lunch
□After Dinner □At bedtime
What is the name of your blood sugar meter: _____
In the last 7 days, what was your highest and lowest blood sugar? Highest:_____ Lowest:_____
List any allergies to medications:_____

List all medications, vitamins, and herbs that you are currently taking (include doses and how often): _____

_____

_____

Tobacco use? □Yes □No Type of tobacco product:_____ How much per day:_____
Do you drink alcohol? □Yes □No How many alcoholic beverages per week:_____

Nutrition and Physical Activity:

Current diet/meal plan:_____

Do you tend to skip meals? □Yes □No If yes, which do you skip: □Breakfast □Lunch □Dinner

Who does your grocery shopping/cooking?_____

How many times a week do you dine out? □≥8 times □5-7 times □3-5 times □2-3 times □1-2 times

Any special dietary needs such as religious considerations or food allergies?_____

List all of the beverages you usually drink:_____

List typical snacks:_____

Do you exercise? How often, and what type of exercise?_____

Additional Information:

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

Please choose an appropriate response for each item:

Little interest or pleasure in doing things

□Not at all □Several days □More than ½ the days □Nearly every day

Feeling down, depressed, or hopeless

□Not at all □Several days □More than ½ the days □Nearly every day

Feeling bad about yourself or that you are a failure, or have let yourself or your family down

□Not at all □Several days □More than ½ the days □Nearly every day

Thoughts that you would be better off dead or hurting yourself in some way

□Not at all □Several days □More than ½ the days □Nearly every day

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Diabetes Treatment Center *Staff* Only: *signature indicates completion of face-to-face assessment*

Reviewer's signature/title and date: _____

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