Huntsville Hospital System

Diabetes and Pregnancy Assessment Form

Name:	Age: DOB:	Name of your glucose meter _____
Referring Physician		Result of blood glucose today _____

Preferred language □English □Other Preferred way to communicate: □verbal □written □sign language other_____

Do you use any of the following □contacts □eye glasses □hearing aids □other_____

How would you rate your reading skills? □good □fair □poor

Date of your Diagnosis: _____ Type of diabetes: ☐ Type 1, ☐ Type 2, ☐ Gestational

Have you had previous gestational diabetes? □yes □no If yes when _____

Have you had any previous diabetes education? □yes □no If yes when/where_____

How many people live with you? _____ How are they related to you?_____ Who do you rely on?_____

Highest Education Level: □ Highschool □ Bachelors □ Post Graduate□ Skills Trade □ Other_____

Exercise Habits: What type? _____ How long? _____Times per week_____

What is your occupation?_____ Days of week you work_____ Shift_____

Employment issues_____ Home issues_____ Other stress issues_____

Previous diets_____ Who does food shopping?_____ Who cooks?_____

Times you eat out week_____ Places you eat out most often_____

Do you have cultural, religious or spiritual beliefs that affect how you eat or care for your body?_____

Height: _____= _____cm Weight: _____lb =_____kg Pre pregnancy weight: _____lb _____kg

Date Due: _____Weeks of gestation:_____ Are you pregnant with twins or triplets?_____

Are you in pain today? □yes □ no Location: _____ Intensity: (0-10) _____ Describe _____

Please list any additional medical conditions _____ Past surgeries_____

Do you currently smoke? □Yes □ No Do you currently drink alcohol □Yes□ No

Do you have abuse/neglect in your home? □Yes □No

Siblings with Diabetes:_____ Children with Diabetes: _____Mother's Family: _____ Father's Family:_____

Have you received a flu shot in the past 12 month? □Yes □ No

Including this pregnancy, how many times have you been pregnant?_____ How many living children do you have?_____

Did any of your babies weigh 8 lbs or more at birth ? ☐ Yes ☐ No Do you plan to breastfeed ? ☐ Yes, ☐ No

In the boxes below, please write the times you eat and and list of what you eat and drink for meals/snacks

Breakfast Time:	Snack Time:	Lunch Time:	Snack Time:	Supper Time:	Before Bed Snack Time:

Patient Label

Patient Signature _____ Date_____

CDE_____ Date _____Time_____

DCCPAS

PG/SS 11/19

HUNTSVILLE HOSPITAL

DIABETES CONTROL CENTER

Ambulatory Summary and Medication Reconciliation List

List all Medications including Over the Counter & Herbal

****Use Lay Terms Only****

MEDHOM

Date / Time	Drug	Dose	Route	How Often	Reason	Reviewed/No Change	Weight	Completed by	Information Obtained from/ Reviewed by	Discontinue/ Date
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Latex Allergy: ☐ Yes ☐ No

Drug/Food/ Environmental Allergies: ☐ NKA

Diagnosis _____

Allergy	Reaction

Pregnant ☐ Yes ☐ No
Lactating ☐ Yes ☐ No
Renal Dysfunction ☐ Yes ☐ No
Liver Dysfunction ☐ Yes ☐ No

Height_____

Patient Label