Name: Name you prefer to be called: DOB: Date:

Lifestyle/Coping and Health Literacy *

Who else in household?_____

Do you work? ☐Yes ☐No Type of work and schedule: _____Primary Language: _____

Race: _____ Please list cultural or religious beliefs that may impactyour care _____

How do you learn best? ☐Written materials ☐Verbal Discussion ☐Video ☐_____

Do you have difficulty with? (Circle all that apply) Listening - Reading – Writing - Hearing - Seeing – Understanding - None of these issues

*Do you need help understanding instructions, pamphlets, or other written material from your doctor or pharmacy? No – Sometimes - Always

What is your sleep schedule, any problems sleeping? _____ _____CPAP used: ☐Yes ☐No

Tobacco Use ☐No ☐Yes Type/Amount/Quit Date: _____Alcohol Use ☐No ☐Type/Amount/Quit Date: _____

Diabetes Distress Support

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What are your feelings about diabetes: ☐Angry/Mad ☐Upset/Sad ☐Frustrated ☐ Anxious ☐ Denial/Disbelief ☐Surprised ☐Concerned ☐Curious ☐Worried ☐Motivated ☐No problem List the hardest thing(s) about diabetes for you?:

_____

How do you deal with this stress/distress? Primary Support Person:

Being Active/Physical Activity **☐ My health care provider has advised me to NOT exercise** **☐ I am on bedrest**

What physical activity to you do regularly? _____How often: _____

What if any barriers do you have to physical activity? What are your hobbies:

Pregnancy and Clinical History

List past or current medical issues, medications, including over the counter medications. Also list any vitamin and supplements you are taking.

Ht.: _____ pre-preg. Wt. _____# Now: _____# Preg with 1 or ____babies? What # pregnancy is this? Other children age(s)

How many weeks pregnant are you now? Due Date: Planned delivery method: Vaginal or C-section

Date of last OBGYN visit: _____ Next Visit: _____

Date of last ultrasound: _____ @ _____ weeks pf preg.

Circle Delivered at 39 weeks or later Yes No How: Vaginal C-section

Circle Previous Pregnancy Issues: GDM - Incompetent Cervix
Pre-Term Labor - Pre- Eclampsia/Eclampsia/Toxemia -Miscarriages
Other Explain

Date of last preg. Related hospital/ER visits and why:

Have you breast feed in the past? ☐ Yes or ☐No
Do you plan to this pregnancy? ☐ Yes or ☐No

Are you aware of the impact that diabetes has on pregnancy?
☐Yes ☐ No

Chronic Complications: Preventing Detecting Treatment

Yes	No	
☐	☐	Do you exam your feet daily?
☐	☐	Did MD exam feet?
☐	☐	Do you see a dentist? Last visit date:
☐	☐	Do you see ab eye doctor? Last visit date:
☐	☐	Did you get the COVID 19 vaccine? Which:
☐	☐	List other vaccines:

Acute Complications: Preventing Detecting Treatment

☐	☐	Hyperglycemia (140 or more)? How often:

How do you treat hyperglycemia?

☐	☐	Have you ever had DKA? When?
☐	☐	Do you ever test for ketones?

What would you do if you have ketones?

☐	☐	Do you have hypoglycemia? (65 or less) How often?
☐	☐	Can you tell when you have hypoglycemia?

What is your Diabetes and Pregnancy Sick Day plan?

What is your Diabetes and Pregnancy plan with medications and supplies in case you had to leave your home with little notice and uncertainty of how long?

Educator Completes from here down on this side

Diabetes Pathophysiology and Treatment

Diabetes type: ☐Pre DM ☐T1DM ☐T2DM ☐ GDM When diagnosed?
Labs (Date: _____ Chol.:_____ HDL:_____ LDL: _____ Tg: _____GFR: ____
Values/Dates: Last A1C Last FBG

If previous diabetes education when/where:

What are your goals for the education session?

Blood Glucose Monitoring (BGM) and Health Literacy*

BGM Times? _____
BGM/CGM type:

BG History: Breakfast: to Lunch to
Dinner to HS to

What are pregnancy glucose targets*?

If using CGM what is your pregnancy TIR target*?

What is your A1C target*?

Taking Medications and Health Literacy* ☐ No DM Medication

DM oral medications/dose*/can it cause low glucose*?

Insulin/DM Injectables: Type/when/dose*/sliding scale*/sites/storage/can it cause low bgs*? (If insulin: Pens, Vials, Pump)

In a typical week how many times do you miss taking your diabetes medicine?

Healthy Eating and Health Literacy* Add 24-hour recall with times on the back.

Current and past Meal Plans: _____
_____

Knows which foods raise glucose*? _____
Can read food labels*? Lunch ☐Yes Lunch ☐No
Food allergies/ GI issues: _____
Who shops/cooks: _____
Meals eaten: ☐ Breakfast ☐ Lunch ☐Dinner ☐ Snacks
Food Beverage Snack Notes:

Educators Signature/Date