|  |  |  |
| --- | --- | --- |
| 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 impact your 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? o Excellent o Good o Fair o Poor  What are your feelings about diabetes: oAngry/Mad oUpset/Sad oFrustrated o Anxious o Denial/Disbelief oSurprised oConcerned oCurious oWorried oMotivated oNo 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** o **My health care provider has advised me to NOT exercise** o **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 | | |
|  | | ***Educator Completes from here down on this side*** |
| Date of last OBGYN visit: \_\_\_\_\_\_\_\_\_\_\_\_\_ Next Visit: \_\_\_\_\_\_\_\_\_\_\_\_ Date of last ultrasound: \_\_\_\_\_\_\_\_\_\_\_\_\_ @ \_\_\_\_\_\_\_ weeks pf preg. | | **Diabetes Pathophysiology and Treatment** |
| Diabetes type: oPre DM oT1DM oT2DM o GDM When diagnosed?  Labs (Date: \_\_\_\_\_\_\_ Chol.:\_\_\_\_\_ HDL:\_\_\_\_\_\_\_\_ LDL: \_\_\_\_\_ Tg: \_\_\_\_\_GFR: \_\_\_\_ Values/Dates: Last A1C Last FBG |
| 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 | |
| If previous diabetes education when/where: |
| What are your goals for the education session? |
| Date of last preg. Related hospital/ER visits and why: | | **Blood Glucose Monitoring (BGM) and Health Literacy\*** |
| BGM Times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  BGM/CGM type: |
| Have you breast feed in the past? o Yes or oNo  Do you plan to this pregnancy? o Yes or oNo | |
| Are you aware of the impact that diabetes has on pregnancy?  oYes o No | | BG History: Breakfast: to Lunch to  Dinner to HS to |
| **Chronic Complications: Preventing Detecting Treatment** | | What are pregnancy glucose targets\*? |
| **Yes No** |  | If using CGM what is your pregnancy TIR target\*? |
| o o | Do you exam your feet daily? | What is your A1C target\*? |
| o o | Did MD exam feet? | **Taking Medications and Health Literacy\*** o No DM Medication |
| o o | Do you see a dentist? Last visit date: | DM oral medications/dose\*/can it cause low glucose\*? |
| o o | Do you see ab eye doctor? Last visit date: |
| o o | Did you get the COVID 19 vaccine? Which: | Insulin/DM Injectables: Type/when/dose\*/sliding scale\*/sites/storage/can it cause low bgs\*? (If insulin: Pens, Vials, Pump) |
| o o | List other vaccines: |
| **Acute Complications: Preventing Detecting Treatment** | | In a typical week how many times do you miss taking your diabetes medicine? |
| o o | Hyperglycemia (140 or more)? How often: |
| How do you treat hyperglycemia? | | **Healthy Eating and Health Literacy\*** Add 24-hour recall with times on the back. |
| o o | Have you ever had DKA? When? | Current and past Meal Plans: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Knows which foods raise glucose\*? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Can read food labels\*? Lunch oYes Lunch oNo  Food allergies/ GI issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Who shops/cooks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Meals eaten: o Breakfast o Lunch oDinner o Snacks  Food Beverage Snack Notes: |
| o o | Do you ever test for ketones? |
| What would you do if you have ketones? | |
| o o | Do you have hypoglycemia? (65 or less) How often? |
| o o | 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? | | **Educators Signature/Date** |