THE TEXAS PERINATAL GROUP
DIABETES PROGRAM

DIABETES QUESTIONAIRE

Name:_____Date of Birth_____ Age_____ Date:_____
Last Menstrual Period:_____ Due Date:_____OB/GYN:_____

Reason for your appointment today?
Gestational Diabetes____
Type 1___or Type 2____ Diabetes What age were you diagnosed?_____ Year?_____

Past Medical History:
Drug allergies?_____
Past surgeries & dates?_____
Past hospitalizations & dates?_____
Do you have high blood pressure?_____
Other medical problems? _____

Social History:
Married/ Single/ Divorced/ Widow
Where do you work?_____ Occupation: _____Night hours? Yes/ No
How much do you smoke per day?_____ Alcohol per day?_____ Drug use?_____
How often do you exercise?_____ What type of exercise?_____

Family History: Please list the family members with the following illness
Diabetes: _____
High blood pressure:_____
Heart Disease:_____
Blood Clots:_____
Kidney disorder:_____
Other significant illness :_____

Pregnancy History:
How many of your pregnancies were Full Term ____ Pre-term (<37wks)____ Miscarriages___
Abortions____ Ectopic Pregnancies____ How many living children do you have? _____

Please complete the table below starting with your first pregnancy:

Year	Weeks	Hours in Labor	Birth Weight pounds/ounces	Sex M/F	Vaginal or C/ section	Place of Delivery	Diabetes? Yes/ No

EGA:_____ BS:_____Weight_____ ADA Calories:_____GTT____/____/_____/_____
Meter:_____ Supplier: RX or _____
Medication Started:_____

Review of Health Systems:

Please check the box if you are having problems with:

- ☐ Fever
- ☐ Eye sight
- ☐ Irregular heart rate
- ☐ Nausea or Vomiting
- ☐ Frequent hunger
- ☐ Pain during urination
- ☐ Unusual swelling in legs
- ☐ Weight Loss
- ☐ Dizziness
- ☐ Breathing difficulty
- ☐ Constipation or Diarrhea
- ☐ Frequent thirst
- ☐ Frequency of urination
- ☐ Unusual skin rashes

Current Information:

Age:____ Height:_____ Pre-Pregnant Weight:_____
What medications are you taking currently?_____
What medications were you taking for diabetes before pregnancy?_____
_____
Do you currently test your blood sugar? Yes_____ No_____
What kind of glucose meter do you use? _____
When do you test? Fasting?____ After Meals?_____ Before Meals?_____ Bedtime?_____
What do you consider a low blood sugar?_____ How often do you have a low sugar?_____
When was your last eye exam?_____ Hemoglobin A1C?_____
When have you collected a 24 hour urine sample?_____

Dietary Information:

Have you ever seen a nutritionist or a dietitian Yes/ No. If yes, When?_____
What times do you eat your meals? Breakfast_____ Lunch_____ Dinner_____
What times do you eat your snacks? _____
Do you eat sweets? Yes___ No___ Drink Sodas? Yes__ No___ Drink Milk? Yes____ No___

Please write down examples of the foods you eat during a regular day in the space below:

Breakfast	Lunch	Dinner	Snacks