OBSTETRIX MEDICAL GROUP

History Questionnaire

for Sweet Success (Diabetes in Pregnancy Program)

YES NO

____ ____ (1) Did you have diabetes BEFORE this pregnancy?

___ Gestational diabetes in a prior pregnancy

___ Type 1

___ Type 2

____ ____ (2) Are you ALLERGIC to any medications?

List medication allergies_____

_____

____ ____ (3) Do you have any food allergy or food intolerance?

Explain_____

_____

____ ____ (4) Are you taking vitamins?

____ ____ (5) Are you taking iron, calcium, or other mineral supplements?

____ ____ (6) Are you taking any OTHER medications?

List all other medications_____

_____

_____

Prior Pregnancies

Year	Weeks	Birth Weight Pounds + Oz	Any Diabetes? (Type?) (Y or N)	High Blood Pressure (Y or N)	Other Problems (for example, miscarriage, ectopic, termination, prematurity, others)

Patient Signature_____ Date_____

**********Office Use Only**********

_____Reviewed Date_____

Revision 9/3/14

Important: This form can be saved and uploaded into the Patient Registration form section.