Center for Diabetes Gestational Health History

Name: ______________________ Date of Birth: ______________ Age: ______________

Home/Cell Phone: ____________ Work Phone: ____________ May we call you at work? ❑ Yes ❑ No

Highest grade completed: ________________ Preferred Language: ________________

Occupation: ______________________ Employer: ______________________

Email Address: ____

❑ Single ❑ Married ❑ Divorced ❑ Widowed

Primary support person: ______________________ Relationship: ______________________

Do you feel that you have an unusual amount of stress in your life? ❑ Yes ❑ No If yes, what is / are the major sources of stress in your life? ❑ Work ❑ Family ❑ Illness ❑ Financial ❑ Other:

____

How do you cope with your stress? ____

Height: __________ Weight Today: __________ Pre–pregnancy Weight: ______________________

Name of your OB Doctor: ______________________ Due Date: ______________

Number of weeks pregnant you are? __________ Expecting: ❑ Boy ❑ Girl ❑ Unknown

Number of pregnancies: ______________ Number of Live births: ______________

Any babies over 9 pounds at birth? ______________________________

Any pregnancy complications? ______________________________

Have you had gestational diabetes in a previous pregnancy? ❑ Yes ❑ No
If yes, how was it treated? Diet: __________ Medication: ______________________

Do you have any family members with diabetes? ❑ Yes ❑ No

Are you already testing your Blood Sugar? ❑ Yes ❑ No If so, name of your meter: ______________

Do you have any problems with blood sugars going too low? ❑ Yes ❑ No
If yes, how often? ______________________

Are you presently being treated for any other medical conditions? ❑ Yes ❑ No
If yes, what? ____

Are you on any prescription/non–prescription medications? ______________________________
______________________________ Drug allergies? ______________________________