Baptist Health

Center for Diabetes Gestational Health History

Do you exercise ❑Yes ❑No Type of exercise you do: _____

How often? times per ❑ Day ❑Week ❑ Month For how long per session?_____

How physically active are you at work?_____

Do you drink alcohol? ❑Yes ❑ No What kind?_____How many drinks per week?_____

Do you use tobacco? ❑Yes ❑ No What form? How much?

In the past 6 months, how often:	# of times	Reason
Did you see your primary care physician?	_____	_____
Did you see your OB doctor?	_____	_____
Were you hospitalized?	_____	_____
Did you go to the emergency room?	_____	_____

Are you currently following any special diet restrictions?_____

How many times a day do you eat, including meals and snacks?_____

What beverages do you drink everyday?_____

Cultural or religious customs affecting your food choices or medical care?_____

How do you feel about having gestational diabetes?_____

Please list three things that you hope to learn / achieve by participating in this program:

1. _____

2. _____

3. _____

PLEASE DO NOT WRITE IN THIS BOX −OFFICE USE ONLY Weight:_____ Date:_____

3 Hr GTT: FBS _____ 1/2 Hr_____

1 Hr_____ 2 Hr_____ 3 Hr _____ Date:_____

Other labs:_____

Comments:_____

_____

_____

_____

_____

RN/RD Name(Print): _____

RN/RD Signature: _____ Time:_____ Date:_____

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