Duke Primary Care Diabetes Education Program
Gestational Diabetes Patient Information

Name_____________________________________ Age____________

Height _________ Current Weight __________ Pre-Pregnancy Weight ________
Number of weeks Pregnant __________________ Twins? ☐ Yes ☐No
Date of Last Menstrual Period ____
Are you currently employed? ☐ Yes ☐No
Occupation? ___________________________Work hours ___________________

NUTRITION

Do you follow a special diet? ☐Yes ☐No
If so, what are your food restrictions? ____________________________________
What is the hardest part about staying on track with healthy eating?
____
How many meals do you eat a day? _____How many snacks do you eat a day? ___
How many times per week do you eat out? _____
Which type of restaurants? ____

Please provide a sample of your meals and snacks for a typical day:
Time: ____ Meal 1: ____
Time: ____ Snack: ____
Time: ____ Meal 2: ____
Time: ____ Snack: ____
Time: ____ Meal 3: ____
Time: ____ Snack: ____
What do you drink on a regular basis? ____________________________________

PHYSICAL ACTIVITY

Do you exercise? ☐Yes ☐No Type of exercise: _____________________
How many times a week? ______ for how many minutes? __________________
Are you active at work? ☐Yes ☐No Please describe activity: _____________

MEDICATION

Do you take any diabetes medications? ☐Yes ☐No
If Yes Name and Dose: _________________________
Are you currently taking a prenatal vitamin? ☐ Yes ☐No

TESTING BLOOD SUGAR

Do you check blood sugar at home? ☐Y ☐N How many times a day?_________
What is the typical range of your blood sugar numbers? ______________________