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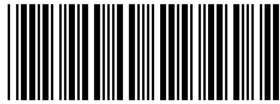

166015

DIABETES LIFECARE PROGRAM
Prenatal Questionnaire

Name: ____ Date:_____________________
Address:____
Home Phone: ( ) _____________________ Work Phone: ( ) _____________________
Cell Phone: ( ) _____________________ Date of Birth: _____________________________
E-Mail Address :_____________________________

Referring Physician: ____________________________________ Phone #: ( ) _________________

Primary Care Physician (PCP): ____________________________ Phone #: ( ) _________________
Race/Ethnicity: ❒ Non-Hispanic White ❒ African American ❒ Hispanic American ❒ Native American
❒ Asian American ❒ Other (specify) ____

When is your Due Date? ___________________
Number of prior pregnancies: _________
Are you carrying? ❒ Single ❒ Twins ❒ Triplets ❒ Other (specify) ___________________________
Please list the age and birth weight of your other children:

Age: _____ Birth Weight: ______ Age: _____ Birth Weight: ______
Age: _____ Birth Weight: ______ Age: _____ Birth Weight: ______

History of stillbirth or miscarriage? ❒Yes ❒No If yes, dates: _____________________________________

Did you have high blood sugars with your previous pregnancies? ❒Yes ❒No
If yes, did you receive any diabetes education? ❒Yes ❒No If yes, Year_______
Where: ____

Do you have a history of pregnancy complications? ❒Yes ❒No
Please List: ____

Does anyone in your family have diabetes? ❒Yes ❒No If yes, who: ______________________________

Do you have any other medical problems *(illness before pregnancy)*? ❒Yes ❒No
If yes, please list: ____

Do you take any medications? ❒Yes ❒No If yes, Please list:

___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________

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DIABETES LIFECARE PROGRAM
Prenatal Questionnaire

Do you smoke? ❐Yes ❐No If yes, how many cigarettes per day? ____________________

Do you drink alcoholic beverages? ❐Yes ❐No If yes, how much? ____________________________________

Please answer the following to help us determine the correct meal plan for you:

Age: _____ Height: _____ Last weight at Doctor's office: _________ Pre-pregnancy weight: _________

Do you take vitamins and/or supplements? ❐Yes ❐No If yes, what kind? ______________________________

How is your appetite? ❐ Good ❐ Fair ❐ Poor Any recent appetite changes? ❐Yes ❐No

If yes, please describe: ____

Do you have any food allergies? ❐Yes ❐No

If yes, please describe: ____

Do you have any food intolerances *(lactose, spicy foods, etc)*? ❐Yes ❐No

If yes, please describe: ____

Are there any foods that you dislike and will not eat? ❐Yes ❐No

If yes, please describe: ____

If you are employed, what type of work do you do? ____

What shift do you work? ❐ Days ❐ Evenings ❐ Nights ❐ Rotating

Who prepares your food? ________________________ Who does the grocery shopping? ____________________

Do you engage in a regular exercise program? ❐Yes ❐No If yes, answer the following:

Type of exercise: _____________________ How often? ___________________ How long? ________________

Your meal plan will spread your calories/carbohydrates over 3 meals and 3 snacks each day. Please list below what you eat in a typical day. Please be as specific as possible:

Breakfast **What Time?** __________

____

____

____

____

A.M. Snack **What Time?** __________

____

____

____

____

Lunch **What Time?** __________

____

____

____

____

P.M. Snack **What Time?** __________

____

____

____

____

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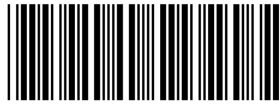

DIABETES LIFECARE PROGRAM
Prenatal Questionnaire

Dinner **What Time?** __________

____
____
____
____

Evening Snack **What Time?** __________

____
____
____
____

Please indicate how much of the following foods you eat or drink each day:

Milk: No. of cups per day: _____ ❒ Whole ❒ 2% ❒ 1% ❒ Skim ❒ Soy
If you drink less than 3 cups of milk per day, could you drink more? ❒Yes ❒No
How much more? ❒ 1 cup ❒ 2 cups ❒ 3 cups

Calcium supplement: ❒Yes ❒No What kind? ______________ How many? ____________

Yogurt (6 or 8 oz): ❒Yes ❒No How many per day? _______

Fruit: ❒Yes ❒No How many per day? ❒1 ❒ 2 ❒ 3 or more
List the times of day you like to eat fruits: ______________________________________
Please list fruit that you like to eat: ______________________________________

Vegetables: ❒Yes ❒No ❒ ½ cup to 1 cup per day ❒ 1 cup at each lunch and dinner
Please list vegetables that you like to eat: ______________________________________
____

Please select all of the following protein foods that you like or would try:

❒ Peanut Butter ❒ Lower Carbohydrate "Milk" ❒ Soy Milk ❒ Cottage Cheese ❒ Canned Tuna (max: 1 can/wk)
❒ Nuts ❒ Deli Meats (heated/steam hot) ❒ Tofu ❒ Cheese ❒ Eggs

For clinical use only:
Initial Visit

Diabetes Type: Gestational: ______ Type 1: ______ Type 2: ______

Pre-pregnancy BMI: _______ Present BMI: _______ Weeks pregnant at time of dx: _________

1-hour Challenge: _______

FBS: _______ 1-hour: ________ 2-hour: ________ 3-hour: ________

Current pregnancy complications: ____

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