



Name: \_\_\_\_\_

Please check, if you are having problems with:

- Fever
- Eyesight
- Irregular heart beat
- Nausea or Vomiting
- Frequent hunger
- Pain during urination
- Unusual swelling in legs
- Weight Loss
- Dizziness
- Breathing difficulty
- Constipation/Diarrhea
- Frequent thirst
- Frequency of urination
- Unusual skin rashes

**Current Information:**

Height: \_\_\_\_\_ Pre-Pregnancy Weight: \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_

Prenatal Vitamins? Yes/No

What medications/supplements were taking for diabetes before pregnancy? \_\_\_\_\_

Do you currently test your blood sugar: Yes/No

What kind of meter do you use? \_\_\_\_\_

When do you test? Fasting? \_\_\_\_\_ Before Meals? \_\_\_\_\_ After Meals? \_\_\_\_\_ Bedtime? \_\_\_\_\_

What do you consider as a low blood sugar? \_\_\_\_\_

How often do you have a low blood sugar? \_\_\_\_\_

When was your last dilated eye exam? \_\_\_\_\_ Hemoglobin A1C? \_\_\_\_\_

When have you collected a 24 hour urine sample? \_\_\_\_\_

**Dietary Information:**

Have you seen a nutritionist or a dietitian? Y/N If yes, when? \_\_\_\_\_

What times do you eat your meals? Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_

What times do you eat snacks? \_\_\_\_\_

Do you eat sweets? Y/N Drink Sodas? Y/N Drink Milk? Y/N  
Diet/regular Whole/2%/Skim/Non Fat

Please write down, in the space below, examples of the foods you eat during a regular day.

Breakfast	Lunch	Dinner	Snacks

**For Educator only**

EGA \_\_\_\_\_ BS \_\_\_\_\_ Weight \_\_\_\_\_ Diet Calories \_\_\_\_\_ GTT \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

Meter: \_\_\_\_\_ Supplier: Rx or \_\_\_\_\_

Medication Started: \_\_\_\_\_