Dear Patient:

Welcome to Gestational Diabetes Education Program of the Metabolic Health Center! Our staff of certified diabetes educators will help you learn to manage gestational diabetes through nutrition, exercise, blood sugar monitoring, and sometimes, medication.

Please note that your insurance company will be billed for these services unless other arrangements were made before your scheduled appointment. You will be responsible for any unmet deductible, co-payment, or coinsurance. Should you have any questions regarding insurance coverage, please call your insurance company directly first and let them know that we are a hospital outpatient facility and the procedure code is G0108 and G0109 (diabetes education). After speaking with your insurance company, if you have any additional questions, please do not hesitate to call us.

Once we receive a completed referral from your doctor, we will call to schedule your appointment. Please bring the following items to your first appointment:

- Completed paperwork
- Blood sugar meter (if you currently are testing your blood sugars)
- Current insurance card
- Photo identification

If you have any questions or need to change the date or time or your appointment, please contact our office at 850/431-5404, option 3. Please note that you also may be asked to reschedule your appointment if you arrive more than 10 minutes late.

We look forward to being part of your team in gestational diabetes management.

Sincerely,

TMH PP Metabolic Health Center Administration
DIABETES & PREGNANCY QUESTIONNAIRE

Today’s date: ____________________________

Name: ___________________________________ DOB: ___________ Age: _______ Race: ______________

Address: __________________________________________________________________________________________

Home Phone #: __________________________ Work Phone #: __________________________ Cell Phone #: __________________

Emergency Contact: ___________________________________________ Phone #: ____________________________

Height: _______________ Weight when you became pregnant: _______________ Due Date: _________________

Type of diabetes: □ Gestational diabetes □ Type 1 diabetes/ how long? _______

□ Type 2 diabetes/ how long? _______

Level of education completed: □ Grade school □ High school □ College □ Trade School

How do you learn best? □ Reading □ Listening □ Demonstration □ Hands-on □ Other: _______________________

OB/GYN Physician: _______________________________ Primary Care Physician: ___________________________

What language do you prefer using in discussing your health care? □ English □ Other: __________________________

OBSTETRICAL HISTORY

Number of previous pregnancies? ____ Number of living children? _____ How many full-term? _____ Premature? _____

Are you having twins? □ No □ Yes

Have you had a miscarriage or stillborn birth? □ No □ Yes, explain: _______________________________________

Birth weight of your children: _____________________________________________________________________

Have you had gestational diabetes before? □ No □ Yes

Have you had any other complications during previous pregnancies? □ No □ Yes, explain: _______________________

GENERAL MEDICAL HISTORY

Do you have any questions about your medications? □ No □ Yes

Are you experiencing any of the following: Nausea: □ No □ Yes Vomiting: □ No □ Yes

Constipation: □ No □ Yes

Have you had problems with:

High blood pressure: □ No □ Yes Kidneys: □ No □ Yes Pre-term labor: □ No □ Yes

Chronic pain: □ No □ Yes Eyes: □ No □ Yes When did you have your last dilated eye exam? _______
HEALTH HABITS
Do you drink alcoholic beverages (wine, beer, etc.)? □ No □ Yes. What and how often? __________________________
Do you smoke or chew tobacco? □ No □ Yes, how many cigarettes each day? __________________________
Please indicate the typical amount of physical exercise in your day: □ Little □ Moderate □ Active
List the type of exercise you do (work or recreation): ______________________________________________________
Are you in a family situation where you fear for your safety? □ No □ Yes
Do you use recreational drugs (marijuana, ______________________)? □ No □ Yes, how often? __________________________
Do you have any religious or cultural personal health beliefs or habits you would like considered as we help you develop your diabetes care plan? ______________________________________________________

FOOD HABITS
Do you drink coffee or other drinks that contain caffeine? □ No □ Yes, what and how often? __________________________
Do you drink sugar sweetened beverages (sweet tea, sodas, Koolaid, etc.)? __________________________
What meal do you skip the most often? ______________________________________________________
How many servings do you usually eat each day of milk or dairy products? __________________________
How many servings do you usually eat each day of fruits and vegetables? __________________________
How many times/week do you eat fish? _________ What types of fish? __________________________
Do you crave or eat any items that are no food? □ No □ Yes. please list: _______________________________________
Are there foods that upset your stomach? □ No □ Yes, please list: _______________________________________
Are you allergic to any foods? □ No □ Yes, please list: ____________________________________________________
Do you eat raw fish/seafood, meats, eggs, and or milk? □ No □ Yes, please list: ________________________________

Please list below everything you had to eat and drink yesterday:
Breakfast: Time: _____ Am/Pm Food/Drink: ______________________________________________________
Lunch: Time: _____ Am/Pm Food/Drink: ______________________________________________________
Dinner: Time: _____ Am/Pm Food/Drink: ______________________________________________________
Snack(s): Time: _____ Am/Pm Food/Drink: ______________________________________________________
Are you using WIC or food stamps? __________________________
How do you plan to feed your baby? □ Breast feed □ Bottle

NAME________________________________________________________ DOB ________________________________
Last Revised:5/17
**Notice to Patient**  Keep an updated medication list with you at all times in case of emergency situations. Update the information when medications are changed or discontinued. If you have been seen for a consult, give a copy of your medication list to your Primary Care Physician.

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