The Diabetes Education Programs of the
TMH Physician Partners- Metabolic Health Center

2633 Centennial Blvd, Suite 100
Tallahassee FL 32308
(850)431-5404 / FAX (850)431-4838

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 they 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

For Office Use Only
ICD-10- Code: _____

Name:__________________________________ **DOB:**______________ **Physician:**____________________________
Pharmacy:____
Medication Allergies:____

Medication name	Dose	Taken by	Frequency (times per day)
		□ mouth □ injection □ inhaled □ ___________	
		□ mouth □ injection □ inhaled □ ___________	
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Reviewer Signature/Date/Time

Signature	Date	Time
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** 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.