Diabetes Self-Management Program
E.C.H.N.

GESTATIONAL LIFESTYLE QUESTIONNAIRE

Name_____ Date of Birth _____

GENERAL INFORMATION

1. **What were your thoughts when you were first told that you had diabetes?**
   _____

2. **Marital status (please circle):**
   Never married Married Separated Divorced Widowed

3. **Which family members and/or friends help you manage your diabetes?**
   _____

4. **Highest level of school completed:**
   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

5. **Number of people living in the household (excluding the patient):**
   Adults (18 years and over)_____ Children_____

6. **Occupational Status: Employed (Y/N)____ Occupation_____**
   How satisfied are you with your current position?_____

7. **Describe your activities for a 24-hour day:_____**
   _____
   _____

MEDICAL HISTORY

1. **Do you have an OB-GYN physician? (Y/N)_____**

2. **How frequently do you see a physician regarding your diabetes care?**
   _____

3. **When is your due date?_____**

4. **Is there any previous history of gestational diabetes? (Y/N)_____**

GESTATIONAL LIFESTYLE QUESTIONNAIRE (continued)

5. Is there any family history of diabetes? (Y/N)_____
If yes, who in family_____

6. How many pregnancies have you had?_____ How many living children?_____

7. Have any pregnancies been above 9 pounds? (Y/N)_____

If yes, number_____, _____lbs.

8. Do you smoke cigarettes? (Y/N)_____ If yes, how many packs a day?_____

9. Do you drink alcohol? (Y/N)_____ If yes, what do you drink?_____

10. Do you smoke, inhale, or inject recreational drugs? (Y/N)_____

11. Do you have any of the following conditions along with your diabetes?

Cataracts___
Skin Problems___
Eyesight worsened___
Heart problems___
Sexual problems___
Pain/numbness in feet or legs___
High blood pressure___
Foot problems____
Kidney problems___

Please list any current medications you are taking:
_____
_____

12. Do you have any allergies? (Y/N)_____

<u>DIET</u>

1. Do you eat 3 meals a day? (Y/N)___

2. At what times are you presently eating your meals?

Breakfast_____ Lunch_____ Supper_____

3. Do you have between-meal snacks? (Y/N)___

GESTATIONAL LIFESTYLE QUESTIONNAIRE (continued)

EXERCISE

1. Is exercise a part of your diabetes regimen? (Y/N)_____

If yes, describe type, frequency and duration of exercise

Type of exercise (i.e., brisk walking)	Number of times per week (3)	Duration of exercise (40 minutes each time)

SUMMARY

1. What is causing you the most distress at this time?
_____

2. What do you do when you are feeling upset?
_____

3. What is your major concern regarding your gestational diabetes?
_____

4. Do you feel that your husband/significant other is supportive? (Y/N)_____

5. What is your goal for coming here?
_____

All information contained in this questionnaire will be kept confidential and used for diabetes instruction only.

_____ _____
Name **Date**