The Hospital of Central Connecticut
Center for Metabolic Health

## Gestational Diabetes Questionnaire

**Please take a few minutes to complete this form. Thank you.**

Name_____ DOB_____ Today's Date_____

Is this your first pregnancy? Yes ☐ No ☐ When is your estimated due date? _____

If no, have you had gestational diabetes in a previous pregnancy? ☐ Yes ☐ No

In the previous pregnancy, did you need to use insulin to control your blood sugars? ☐ Yes ☐ No

Please list the ages and birth weights of your other children, and how many weeks you were at each delivery:
_____

Were there any complications during or after these deliveries? ☐ Yes ☐ No

If yes, please describe_____

Who is/are your main support person/people? _____

Do you smoke (i.e. cigarettes, marijuana, vape)? ☐ Yes ☐ No Are you currently drinking alcohol? ☐ Yes ☐ No

Do you have any food allergies? Yes ☐ No ☐ If yes, please list: _____

Do you have any food intolerances? I.e. lactose, gluten? ☐ Yes ☐ No If yes, please list: _____

Do you have any religious, cultural or personal health beliefs that you would like considered as we help you develop your diabetes care plan? ☐ Yes ☐ No If yes, describe_____

**PHYSICAL ACTIVITY:**

Has your provider restricted your exercise/physical activity? ☐ Yes ☐ No

If no, what type of exercise/physical activity do you do? _____

How many days per week do you engage in regular exercise? ☐ 0 to 2 days ☐ 3 to 4 days ☐ 5 to 7 days

How long do you exercise per session? ☐ 0- 15 minutes ☐ 15-30 minutes ☐ 30-60 minutes ☐ 60 minutes +

**WEIGHT HISTORY:**

Height_____ Pre-Pregnancy Weight_____ Current Weight_____

Did your provider give you a specific weight gain goal for this pregnancy? ☐ Yes ☐ No

If yes, what weight range? _____

**(Continued)**

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**Gestational Diabetes Questionnaire (Continued)**
Name_____ DOB_____
**DIET HISTORY:**

Do you drink water? ☐ Yes ☐ No If yes, how many cups per day? _____ (1 cup is 8 ounces)

Do you drink juice? ☐ Yes ☐ No If yes, how many cups per day? _____

Do you drink milk? ☐ Yes ☐ No If yes, how many cups/day? _____ What type of milk? _____

Do you drink coffee/tea? ☐ Yes ☐ No If yes, how many cups/day? _____ Do you add sugar/creamer? ☐ Yes ☐ No

Do you drink soda? ☐ Yes ☐ No Regular ☐ Yes ☐ No Diet ☐ Yes ☐ No How many ounces/day? _____

How often do you eat out/order takeout per week? ☐ 0 to 2 days ☐ 2 to 4 days ☐ greater than 4 days/week

**Please write down what a typical day of eating is for you. Please include beverages as well.**

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

**Check any problems you may be experiencing:**

☐ High Blood Pressure ☐ Morning Sickness ☐ Nausea ☐ Vomiting ☐ Heartburn ☐ Other: _____

Within the past 12 months, have you had an eye exam? ☐ Yes ☐ No

Within the past 12 months, I worried whether my food would run out before I/we had money to buy more: ☐ Yes ☐ No

Within the past 12 months, the food purchased did not last and I/we did not have money to buy more: ☐ Yes ☐ No

Do you receive WIC benefits? ☐ Yes ☐ No Are you interested in receiving information about WIC? ☐ Yes ☐ No

Are you interested in receiving information about breastfeeding? ☐ Yes ☐ No

**Please list any medications, vitamins, minerals and other supplements you are currently taking and their doses:**

_____

***Thank you for providing us with this information to help you with your treatment plan for your gestational diabetes.***