Questionnaire for Gestational Diabetes

Name: _____

AB Health Care #: _____

Email address: _____

Primary language(s): _____

Will you need an interpreter? ◯ Yes ◯ No

Name of family doctor: _____ Name of doctor delivering baby: _____

Due date of baby: _____ Please list your weight before this pregnancy: _____lbs/kg

Please list all previous pregnancies:

Date	How long was the pregnancy? (weeks)	Type of delivery (vaginal/c-section/abortion/miscarriage/stillbirth)	Weight of baby	Problems (ie: previous GDM)

Please check any of the problems you are having this pregnancy:

☐ not eating a lot ☐ constipation ☐ heartburn ☐ sick to stomach ☐ other: _____

Please list any medical conditions:

_____

Family history of diabetes? _____

Do you have any allergies and/or foods you cannot eat? ◯ Yes ◯ No If yes, please list:

_____

Please list any medications you are taking and the dose, if you know:

_____

Please list any supplements or vitamins (example- prenatal vitamin) you are taking and the dose, if you know:

_____

Do you smoke? ◯ Yes ◯ No If yes, do you want help to quit smoking? ◯ Yes ◯ No

Do you work outside the home? ◯ Yes ◯ No

If yes, what is your usual work schedule? _____

Are there any big stresses in your life? ◯ Yes ◯ No

If yes: ☐ family ☐ money ☐ health ☐ job ☐ no support ☐ other_____

Are you doing any physical activity (including going for walks)? ◯ Yes ◯ No

If yes, please list the kinds of exercise or activity you do: _____