NEWTON-WELLESLEY HOSPITAL
2014 Washington Street
Newton, Massachusetts 02462

PATIENT IDENTIFICATION AREA

# GESTATIONAL DIABETES SELF-ASSESSMENT

Name: _____ DOB: _____
Phone: _____ Cell/Work _____ Email: _____
Referring Physician: _____ Expected Delivery Date: _____

**Personal History:**
What is your primary language? _____ Language spoken at home _____
Do you have any spiritual/cultural practices that you would like us to include in your care today? ___Yes ___No
Have you had any difficulty caring for yourself at home over the past 3 months? ___Yes ___No

Is anyone in your personal life hurting you or making you feel unsafe? ___Yes ___No
Do you have a health care proxy? ___Yes ___No

Learning Needs Assessment:
How do you learn best? ___by doing ___by reading ___by listening (verbal)
Do you have any trouble understanding written or verbal instructions? ___Yes ___No

**Health Status:**
Do you have allergies to: Medications? Y N Food? Y N Latex Y N Other: _____
Pregnancy: # of pregnancies_____ # of babies >9 lbs._____ Have you had gestational diabetes before? ___Yes ___No
Do you have or have had a problem with the following conditions?
__High blood pressure __Yeast/vaginal infections
__High cholesterol __Anxiety/depression
Do you have any other medical conditions? _____
Pain Assessment
How do you rate your tolerance to pain? ___Low ___Average ___High
Do you have pain now? ___Yes ___No Where is it located? _____
Is your pain: Constant or Comes and Goes (Intermittent)
On a scale of 1-10, with 0 being no pain and 10 being the highest rate of pain, rate what is your pain right now?
1 2 3 4 5 6 7 8 9 10
Fall Risk
Have you fallen in the last 6 months (not from a slip or trip) ___Yes ___No
Are you feeling weak, dizzy, or lightheaded today? ___Yes ___No
Do you need help to walk or change your clothes? ___Yes ___No
Have you every been lightheaded or dizzy before or after having blood drawn or an IV started? ___Yes ___No

**Health Habits:**
Do you smoke? ___Yes ___No If yes, how much? _____
Do you drink alcohol? ___Yes ___No If yes, how much? _____
Do you use street drugs or narcotics? ___Yes ___No If yes, how much? _____

**Exercise & Nutrition:**
What do you do for exercise? _____ How often? _____
Pre-pregnancy Weight: _____ Current Weight: _____ and Height: _____
Please list all vitamins, minerals, or supplements you currently take: _____

Signature:_____ Date:_____ Time:_____