



166015

**DIABETES LIFECARE PROGRAM
Prenatal Questionnaire**

Name: _____ Date: _____

Address: _____

Home Phone: () _____ Work Phone: () _____

Date of Birth: _____

Referring Physician: _____ Phone #: () _____

Race/Ethnicity: Non-Hispanic White African American Hispanic American Native American
 Asian American Other (specify) _____

When is your Due Date? _____

Number of prior pregnancies: _____

Are you carrying? Single Twins Triplets Other (specify) _____

Please list the age and birth weight of your other children:

Age: _____ Birth Weight: _____ Age: _____ Birth Weight: _____

Age: _____ Birth Weight: _____ Age: _____ Birth Weight: _____

History of stillbirth or miscarriage? Yes No If yes, dates: _____

Did you have high blood sugars with your previous pregnancies? Yes No

If yes, did you receive any diabetes education? Yes No If yes, Year _____

Where: _____

Do you have a history of pregnancy complications? Yes No

Please List: _____

Does anyone in your family have diabetes? Yes No If yes, who: _____

Do you have any other medical problems (*illness before pregnancy*)? Yes No

If yes, please list: _____

Do you take any medications? Yes No If yes, Please list:

_____	_____
_____	_____
_____	_____



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Do you smoke? Yes No If yes, how many cigarettes per day? _____

Do you drink alcoholic beverages? Yes No If yes, how much? _____

Please answer the following to help us determine the correct meal plan for you:

Age: _____ Height: _____ Last weight at Doctor's office: _____ Pre-pregnancy weight: _____

Do you take vitamins and/or supplements? Yes No If yes, what kind? _____

How is your appetite? Good Fair Poor Any recent appetite changes? Yes No

If yes, please describe: _____

Do you have any food allergies? Yes No

If yes, please describe: _____

Do you have any food intolerances (*lactose, spicy foods, etc*)? Yes No

If yes, please describe: _____

Are there any foods that you dislike and will not eat? Yes No

If yes, please describe: _____

If you are employed, what type of work do you do? _____

What shift do you work? Days Evenings Nights Rotating

Who prepares your food? _____ Who does the grocery shopping? _____

Do you engage in a regular exercise program? Yes No If yes, answer the following:

Type of exercise: _____ How often? _____ How long? _____

Your meal plan will spread your calories/carbohydrates over 3 meals and 3 snacks each day. Please list below what you eat in a typical day. Please be as specific as possible:

Breakfast What Time? _____ **A.M. Snack** What Time? _____

_____	_____
_____	_____
_____	_____
_____	_____

Lunch What Time? _____ **P.M. Snack** What Time? _____

_____	_____
_____	_____
_____	_____
_____	_____



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Dinner	What Time? _____	Evening Snack	What Time? _____
_____		_____	
_____		_____	
_____		_____	

Please indicate how much of the following foods you eat or drink each day:

Milk: No. of cups per day: _____ Whole 2% 1% Skim Soy
 If you drink less than 3 cups of milk per day, could you drink more? Yes No
 How much more? 1 cup 2 cups 3 cups

Calcium supplement: Yes No What kind? _____ How many? _____

Yogurt (6 or 8 oz): Yes No How many per day? _____

Fruit: Yes No How many per day? 1 2 3 or more

List the times of day you like to eat fruits: _____

Please list fruit that you like to eat: _____

Vegetables: Yes No ½ cup to 1 cup per day 1 cup at each lunch and dinner

Please list vegetables that you like to eat: _____

Please select all of the following protein foods that you like or would try:

- Peanut Butter Lower Carbohydrate "Milk" Soy Milk Cottage Cheese Canned Tuna (max: 1 can/wk)
- Nuts Deli Meats (heated/steam hot) Tofu Cheese Eggs

For clinical use only:

Initial Visit

Diabetes Type: Gestational: _____ Type 1: _____ Type 2: _____

Pre-pregnancy BMI: _____ Present BMI: _____ Weeks pregnant at time of dx: _____

1-hour Challenge: _____

FBS: _____ 1-hour: _____ 2-hour: _____ 3-hour: _____

Current pregnancy complications: _____