HEALTHY SOUTH TEXAS

GESTATIONAL DIABETES REGISTRATION FORM

Class Type:	Class Date:	Assessment Date:

Gestational Diabetes Program Participant Information Sheet

Name:		**Date of Birth:**	
Address:	**City:**	**State:**	**Zip Code:**
County:	**Social Security Number:**		
Phone Number: Home:	**Work:**	**Cell:**	

Language: ❒ English ❒ Spanish ❒ American Sign Language ❒ Other: _____

Present Employment: _____ **Occupation:** _____

At work, I am primarily: ❒ sitting at a desk ❒ standing ❒ walking ❒ very active ❒ I do not work

What level of education have you completed? ❒ No HS ❒ GED ❒ HS ❒ Associates ❒ Bachelors ❒ Grad Degree

Do you have:

❒ Visual Problems ❒ Hearing Problems ❒ Reading Problems ❒ Problems with Understanding English

Gender: ❒ Male ❒ Female **Marital Status**: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Race/Ethnicity: ❒ White ❒ Hispanic ❒ African American ❒ Asian/Pacific Islander ❒ Other

Who helps you with your Diabetes Care?_____

Health History:

I have: ❒ Diabetes ❒ Heart Disease ❒ Cancer ❒ High Blood Pressure ❒ Migraines ❒Seizures

❒ Kidney Disease ❒ Other _____

What type of diabetes do you have? ❒ Type 1 ❒ Type 2 ❒ Pre-diabetes ❒ Gestational ❒ Don't Know

I have had diabetes for _____Months / _____Years

Do you own a glucometer? ❒ **Yes** ❒ **No** **Brand:** _____

Family History: My parent, grand parent or brother or sister has or had:

❒ Diabetes ❒ Heart Disease ❒ Cancer ❒ High Blood Pressure

Do you smoke? ❒ Yes ❒ No **How long have you smoked?** _____ **Number of packs smoked per day** _____

Do you drink alcohol? ❒ Yes ❒ No **How many drinks do you drink per week?** _____

Do you use recreational drugs? ❒ Yes ❒ No **What kind and how often?** _____

Do you have any problems with nausea and vomiting? ❒ Yes ❒ No

Patient Name:	Date of Birth:	Class Date:

Nutrition:

Do you like fruits and vegetables? ❒ Yes ❒ No					
How many fruits and vegetables do you eat on a typical day? (Circle one)	0	1 - 2	3 - 4	5 +	Not Sure

Physical Activity:

How many times do you exercise per week? _____ times _____ minutes
What type of exercise do you do?
Is there a particular reason you cannot exercise? If so, list:

Emotional Health:

Do you feel anxious or depressed about gestational diabetes? If so, explain _____
Are you feeling stressed? ❒ Yes ❒ No If so, what is the cause?
How do you cope with stress?
Who is your emotional support?

Referring Physician: _____ and/or **Clinic:** _____

Insurance Provider: ❒ Private Insurance: _____ ❒ Medicare ❒ Medicaid ❒ NCHD
❒ Other Indigent Program ❒ No Insurance

If no insurance, please answer the following:

Have you enrolled in Obama Care? ❒ Yes ❒ No If No, why? _____

How many people live in your household? _____ What is your annual income? $_____ or monthly $_____

Do you have any food or medication allergies? ❒ Yes ❒ No If yes, please list _____

Current Medication Name (Include vitamins and herbal supplements) **Dosage** **Time of Day Taken**

_____

_____

_____

_____

Please describe the reason for all Hospital or Emergency Room visits in the past year:

Overnight hospital stay: _____

Emergency room visit: _____

Have you lost any days of work due to diabetes? ❒ Yes ❒ No

I do hereby release and forever discharge the Texas A&M University Health Science Center, the Coastal Bend Health Education Center and any participating program of the Coastal Bend Health Education Center, together with such agents, employees, associates, volunteers, successors, assigns, and affiliates from and for any and all liability, claims or causes of action of any nature whatsoever arising out of, or resulting from, any injury, illness, loss or damage, including death, which I may incur as a result of, or in connection with, the performance of said examinations/screening tests, or from the data derived there from.

Signature:_____ **Date:** _____

Person that completed this form: _____ **Relationship to patient:** _____

For office use only: Below 200% poverty level: ❒ Yes ❒ No

10.19.16