DIABETES MANAGEMENT
5008 SOUTHPOINT PARKWAY
FREDERICKSBURG, VA 22407
PHONE: 540-741-2210
FAX: 540-741-2211

INSTRUCTIONS

Please provide the information requested in PART I and III; this information will help us serve you better. You may leave blank any areas of which you are uncertain and the Diabetes Educator will review the information with you during your session.

PART I - TO BE COMPLETED BY PATIENT.

DEMOGRAPHIC INFORMATION

NAME	ADDRESS STREET		CURRENT DATE
HOME PHONE	CITY, STATE, ZIP	OCCUPATION	RACE
WORK PHONE	SOCIAL SECURITY	DATE OF BIRTH	
MARITAL STATUS ☐ S ☐ M ☐ W ☐ D	NAME OF REFERRING PHYSICIAN	NAME OF FAMILY PHYSICIAN	

GENERAL MEDICAL INFORMATION

IF YOU ARE ALLERGIC TO ANY MEDICATIONS, PLEASE LIST THEM.	IF YOU HAVE OTHER ALLERGIES, PLEASE LIST THEM.
PLEASE LIST ANY CHRONIC ILLNESS AND DATE OF DIAGNOSIS	PLEASE LIST DATE/TYPE OF PAST SURGERIES.
PRESCRIBED MEDICATIONS BY MD	OVER THE COUNTER MEDICATIONS
HIGH BLOOD PRESSURE ☐ YES ☐ NO	

PART II - TO BE COMPLETED BY DIABETES EDUCATOR

HEIGHT	WEIGHT	PRE-PREGNANCY WT	EDC	❑ SINGLE BIRTH ❑ MULTIPLE BIRTH
PAST HISTORY OF GESTATIONAL DIABETES: ❑ YES ❑ NO GRAVIDA/PARA ________/_____	DELIVERY GOALS: ❑ NATURAL BIRTH ❑ MEDICATION POST PARTUM GOALS: ❑ BREASTFEED ❑ BOTTLEFEED ❑ COMBINATION	CHILD #1 BIRTH WT _________ ❑ C-SECTION ❑ VAGINAL	CHILD #2 BIRTH WT _________ ❑ C-SECTION ❑ VAGINAL	CHILD #3 BIRTH WT _________ ❑ C-SECTION ❑ VAGINAL
		COMMENTS:		

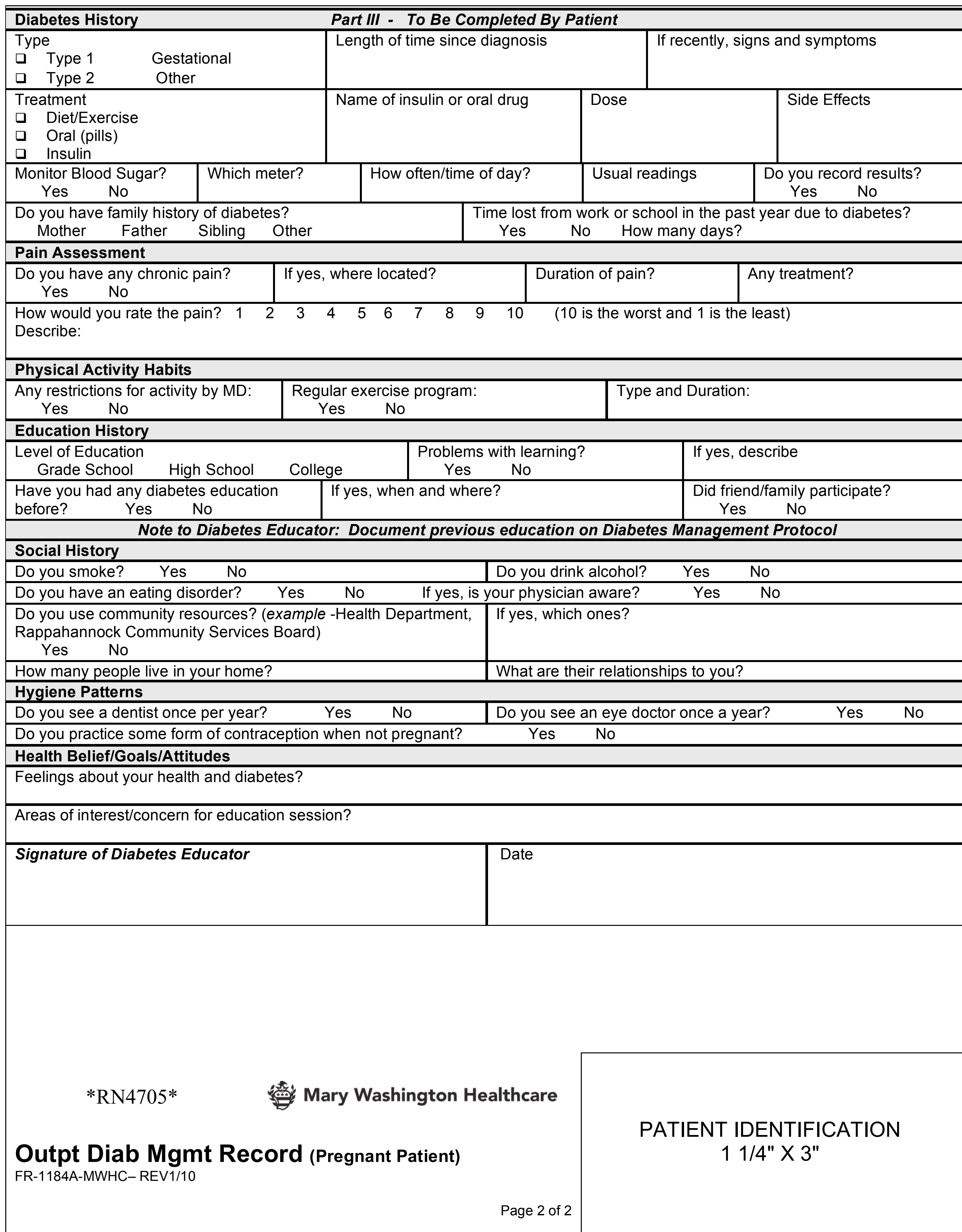
RN4705

Mary Washington Healthcare

Outpt Diab Mgmt Record (Pregnant Patient)

FR-1184A-MWHC – REV.1/10

PATIENT IDENTIFICATION
1 1/4" X 3"



Diabetes History — ***Part III - To Be Completed By Patient***

Type ❑ Type 1 Gestational ❑ Type 2 Other	Length of time since diagnosis	If recently, signs and symptoms

Treatment ❑ Diet/Exercise ❑ Oral (pills) ❑ Insulin	Name of insulin or oral drug	Dose	Side Effects

Monitor Blood Sugar? Yes No	Which meter?	How often/time of day?	Usual readings	Do you record results? Yes No

Do you have family history of diabetes? Mother Father Sibling Other	Time lost from work or school in the past year due to diabetes? Yes No How many days?

Pain Assessment

Do you have any chronic pain? Yes No	If yes, where located?	Duration of pain?	Any treatment?

How would you rate the pain? 1 2 3 4 5 6 7 8 9 10 (10 is the worst and 1 is the least)
Describe:

Physical Activity Habits

Any restrictions for activity by MD: Yes No	Regular exercise program: Yes No	Type and Duration:

Education History

Level of Education Grade School High School College	Problems with learning? Yes No	If yes, describe
Have you had any diabetes education before? Yes No	If yes, when and where?	Did friend/family participate? Yes No

Note to Diabetes Educator: Document previous education on Diabetes Management Protocol

Social History

Do you smoke? Yes No	Do you drink alcohol? Yes No

Do you have an eating disorder? Yes No If yes, is your physician aware? Yes No

Do you use community resources? (*example* -Health Department, Rappahannock Community Services Board) Yes No	If yes, which ones?
How many people live in your home?	What are their relationships to you?

Hygiene Patterns

Do you see a dentist once per year? Yes No	Do you see an eye doctor once a year? Yes No

Do you practice some form of contraception when not pregnant? Yes No

Health Belief/Goals/Attitudes

Feelings about your health and diabetes?

Areas of interest/concern for education session?

Signature of Diabetes Educator	Date

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