Maricopa OBGYN
Women's Health Arizona

WELCOME!

We are excited to help you navigate Gestational Diabetes, working to ensure you and your baby are healthy and safe. We are going to be talking about what you eat, but also how your body processes and utilizes what you eat. We will create a realistic solution for your nutrition and health needs. ***The course is two parts: the initial session that teaches you how to manage Gestational Diabetes, and a follow up appointment one week later to continue your education and make sure everything is going well. You are required to attend both appointments.***

INITIAL SESSION WILL COVER:

- What is Gestational Diabetes?
- How do I manage it?
- What do I eat?
- How to understand nutrition labels
- How to build meals
- How to check and track your blood sugars
- How to feel safe and confident in your blood sugar management moving forward

REQUIRED FOR INITIAL SESSION:

1) Health History Packet & Meal/Blood Sugar Tracking form attached
   - Use food log attached or My Fitness Pal app
2) Glucometer, Lancet, and Testing Strips
3) Cancellation Agreement (below)
4) Spruce app on phone for virtual appointment

If you have any questions, please contact our office at 602-241-1671 or email moganutrition@womenshealthaz.com

CANCELLATION/LATE AGREEMENT:

All appointment cancellations must be completed 24 hours in advance. Failure to cancel within 24 hours will require FULL payment of the service.

Printed name of patient:

_____

I have read and agree to the terms of this cancellation/late agreement:

_____

Signature of Patient/Guardian Date

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Name _____ Date _____

Occupation _____ Age_____ Height_____ Sex _____

Marital Status: ◯Single ◯Partner ◯Married ◯Separated ◯Divorced ◯Widow(er)

Number of Children: _____

Reasons for office visit and onset of condition: _____

_____

List any current health problems for which you are being treated: _____

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health overall:

☐Diet modification ☐Fasting ☐Vitamins/minerals ☐Herbs ☐Homeopathy ☐Chiropractic ☐Acupuncture

☐Conventional drugs ☐Other: _____

Do you experience any of these general symptoms on a regular basis?

☐Debilitating fatigue ☐Shortness of breath ☐Insomnia ☐Constipation ☐Chronic pain/inflammation

☐Depression ☐Panic attacks ☐Nausea ☐Fecal incontinence ☐Bleeding ☐Disinterest in sex ☐Headaches

☐Vomiting ☐Urinary incontinence ☐Discharge ☐Disinterest in eating ☐Dizziness ☐Diarrhea ☐Low grade fever ☐Itching/rash

Current medications (prescription and/or over the counter): _____

_____

_____

Laboratory procedures performed and outcome (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

_____

_____

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Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

_____

_____

_____

Rate your recent average level of stress on a scale of 1 to 10 (1 being the lowest): 10

Identify the major causes of stress (e.g., changes in job, residence, or finances): _____

_____

Do you consider yourself: ○ Underweight ○ Overweight ○ Healthy weight Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? No

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life-threatening activities (e.g., firefighter, police officer, etc.)? _____

_____

What are your current health goals? _____

_____

What are your current health challenges? _____

_____

Please read the following two statements that people have made about their food situation. For each statement, please identify whether the statement was often true, sometimes true, or never true for your household in the last 12 months.

"We worried whether our food would run out before we got money to buy more." Was that often true, sometimes true, or never true for your household in the last 12 months?

○ Often True ○ Sometimes true ○ Never true

"The food we bought just didn't last, and we didn't have money to get more." Was that often true, sometimes true, or never true for your household in the last 12 months?

○ Often True ○ Sometimes true ○ Never true

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Medical History
- ☐Arthritis
- ☐Allergies/hay fever
- ☐Asthma
- ☐Alcoholism
- ☐Alzheimer's disease
- ☐Autoimmune disease
- ☐Blood pressure problems
- ☐Bronchitis
- ☐Cancer
- ☐Chronic fatigue syndrome
- ☐Carpal tunnel syndrome
- ☐Cholesterol, elevated
- ☐Circulatory problems
- ☐Colitis
- ☐Dental problems
- ☐Depression
- ☐Diabetes
- ☐Diverticular disease
- ☐Drug addiction
- ☐Eating disorder
- ☐Epilepsy
- ☐Emphysema
- ☐Eyes, ears, nose,throat problems
- ☐Environmental sensitivities
- ☐Fibromyalgia
- ☐Food intolerance
- ☐Gastroesophageal reflux disease
- ☐Genetic disorder
- ☐Glaucoma
- ☐Gout
- ☐Heart disease
- ☐Infection, chronic
- ☐Inflammatory bowel disease
- ☐Irritable bowel syndrome
- ☐Kidney or bladder disease
- ☐Learning disabilities
- ☐Liver or gallbladder disease (stones)
- ☐Mental illness
- ☐Mental retardation
- ☐Migraine headaches
- ☐Neurological problems (Parkinson's, paralysis)
- ☐Sinus problems
- ☐Stroke
- ☐Thyroid trouble
- ☐Obesity
- ☐Osteoporosis
- ☐Pneumonia
- ☐Sexually transmitted disease
- ☐Seasonal affective disorder
- ☐Skin problems
- ☐Tuberculosis
- ☐Ulcer
- ☐Urinary tract infection
- ☐Varicose veins

Other_____

Medical (Men)
- ☐Benign prostatic hyperplasia
- ☐Prostate cancer
- ☐Decreased sex drive
- ☐Infertility
- ☐Sexually transmitted disease

Other_____

Medical (Women)
- ☐Menstrual irregularities
- ☐Endometriosis
- ☐Infertility
- ☐Fibrocystic breasts
- ☐Fibroids/ovarian cysts
- ☐Premenstrual syndrome (PMS)
- ☐Breast cancer
- ☐Pelvic inflammatory disease
- ☐Vaginal infections
- ☐Decreased sex drive
- ☐Sexually transmitted disease

Other_____
Date of last GYN exam_____
Mammogram + — -
PAP + — -
Form of birth control_____
# of children_____
# of pregnancies_____
C-section_____
Age of first period_____
Date of last menstrual cycle_____
Length of cycle_____ days
Interval of time between cycles
_____ days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)

- ☐Surgical menopause
- ☐Menopause

Family Health History
(Parents and Siblings)
- ☐Arthritis
- ☐Asthma
- ☐Alcoholism
- ☐Alzheimer's disease
- ☐Cancer
- ☐Depression
- ☐Diabetes
- ☐Drug addiction
- ☐Eating disorder
- ☐Genetic disorder
- ☐Glaucoma
- ☐Heart disease
- ☐Infertility
- ☐Learning disabilities
- ☐Mental illness
- ☐Mental retardation
- ☐Migraine headaches
- ☐Neurological disorders (Parkinson's, paralysis)
- ☐Obesity
- ☐Osteoporosis
- ☐Stroke
- ☐Suicide

Other_____
_____

Health Habits
Tobacco:
Cigarettes: # /day_____
Cigars: # /day_____
Alcohol:
Wine: # glasses/d or wk_____Week
Liquor: # ounces/d or wk_____Week
Beer: # glasses/d or wk _____Week
Caffeine:
Coffee: # 6 oz cups/d_____
Tea: # 6 oz cups/d_____
Soda w/caffeine: # cans/d_____
Other sources_____
Water: # glasses/d _____

Exercise
- ○5-7 days/wk
- ⊙3-4 days/wk
- ○1-2 days/wk
- ○45 minutes or more duration per workout
- ⊙30-45 minutes duration per workout
- ○Less than 30 minutes

Walk: #days/wk 7
Run, jog, other aerobic - #days/wk _____7_____
Weight lift: #days/wk 7_____
Stretch: #days/wk 7_____
Other_____

Nutrition & Diet
- ☐Mixed food diet (animal and vegetable sources)
- ☐Vegetarian
- ☐Vegan
- ☐Salt restriction
- ☐Fat restriction
- ☐Starch/carbohydrate restriction
- ☐Total calorie restriction

Specific food restrictions:
☐dairy ☐wheat ☐eggs
☐soy ☐corn ☐gluten
Other _____

Eating Habits
- ☐Skip meals (which ones)_____
_____
- ☐One meal/day
- ☐Two meals/day
- ☐Three meals/day
- ☐Graze (small frequent meals)
- ☐Generally eat on the run
- ☐Eat constantly whether hungry or not

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Name _____ Date _____

Rate each of the following symptoms based on how you have been feeling overall in the past 30 days

Point Scale:
0 — Never or almost never have the symptoms
1 — Occasionally have it, effect is not severe
2 — Occasionally have it, effect is severe
3 — Frequently have it, effect is not severe
4 — Frequently have it, effect is severe

Head	0	Headaches
	0	Faintness
	0	Dizziness
	0	Insomnia
		Total 0
Eyes	0	Watery or itchy eyes
	0	Swollen, reddened or sticky eyelids
	0	Bags or dark circles under eyes
	0	Blurred or tunnel vision (does not include near- or farsightedness)
		Total 0
Ears	0	Itchy ears
	0	Earaches, ear infections
	0	Drainage from ear
	0	Ringing in ears, hearing loss
		Total 0
Nose	0	Stuffy nose
	0	Sinus problems
	0	Hay fever
	0	Sneezing attacks
	0	Excessive mucus formation
		Total 0
Mouth/ Throat	0	Chronic coughing
	0	Gagging, frequent need to clear throat
	0	Sore throat, hoarseness, loss of voice
	0	Swollen/discolored tongue/gums/lips
	0	Canker sores
		Total 0
Skin	0	Acne
	0	Hives, rashes, dry skin
	0	Hair loss
	0	Flushing, hot flashes
	0	Excessive sweating
		Total 0
Heart	0	Irregular or skipped heartbeat
	0	Rapid or pounding heartbeat
	0	Chest pain
		Total 0
Lungs	0	Chest congestion
	0	Asthma, bronchitis
	0	Shortness of breath
	0	Difficulty breathing
		Total 0

Digestive Tract	0	Nausea, vomiting
	0	Diarrhea
	0	Constipation
	0	Bloated feeling
	0	Belching, passing gas
	0	Heartburn
	0	Intestinal/stomach pain
		Total 0
Joints/ Muscles	0	Pain or aches in joints
	0	Arthritis
	0	Stiffness or limitation of movement
	0	Pain or aches in muscles
	0	Feeling of weakness or tiredness
		Total 0
Weight	0	Binge eating/drinking
	0	Craving certain foods
	0	Excessive weight
	0	Compulsive eating
	0	Water retention
	0	Underweight
		Total 0
Energy/ Activity	0	Fatigue, sluggishness
	0	Apathy, lethargy
	0	Hyperactivity
	0	Restlessness
		Total 0
Mind	0	Poor memory
	0	Confusion, poor comprehension
	0	Poor concentration
	0	Poor physical coordination
	0	Difficulty in making decisions
	0	Stuttering or stammering
	0	Slurred speech
	0	Learning disabilities
		Total 0
Emotions	0	Mood swings
	0	Anxiety, fear, nervousness
	0	Anger, irritability, aggressiveness
	0	Depression
		Total 0
Other	0	Frequent illness
	0	Frequent or urgent urination
	0	Genital itch or discharge
		Total 0

Grand Total 0

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Meal/Blood Sugar Tracking Instructions

The tracking record is very important for you and your baby's health. It helps us understand where your body is today - not where you want to be. So please feel comfortable being thorough and honest when tracking. Please use the tracking forms attached. It's important that you bring these with you to every visit with your health care provider.

Keys to successful tracking:

- Type in or write down information right away or as soon as possible after eating each meal or snack. (Don't have time? Take a photo with your phone and record it later)
- Provide the amount: 2 Tbsp. cream, 1 tsp sugar, 1 cup cooked oatmeal
- Include preparation method: fried, baked, breaded, etc.
- Include sauces and other condiments

Feel free to come in with questions and an open mind. At your initial visit we will discuss everything you need to know about Gestational Diabetes, how to manage it, and how to keep you and your baby safe. We look forward to meeting you where you are and working together to get you where you would like to be.

Blood Sugar and Food Record

Blood Sugar Goals: AM Fasting <95 mg/dL, 1 hr after meals <140 mg/dL

Day of the Week	Date	AM Fasting	Breakfast Eaten	1 hour after Breakfast	Lunch Eaten	1 hour after Lunch	Dinner Eaten	1 hour after Dinner
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								
Sunday								

Email Form

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