hoag.
Mary & Dick Allen
Diabetes Center

Sweet Success

SWEET SUCCESS INITIAL QUESTIONNAIRE

A. GENERAL INFORMATION

Name: _____

Date of Birth: _____

Language Preference: ☐ English ☐ Spanish ☐ Other: _____

Highest level of education completed: _____

B. DIABETES & PREGNANCY HISTORY

Relatives with diabetes: ☐ None ☐ Parents ☐ Brothers/Sisters ☐ Grandparents ☐ Spouse/Partner

Is this your first pregnancy? ☐ Yes ☐ No

Number of pregnancies (including this one): _____

How many children have you given birth to? _____

Any twins or triplets? ☐ Yes ☐ No

Any of your children weigh more than 9 pounds at birth? ☐ Yes ☐ No

Have you had any miscarriages and/or abortions? ☐ Yes ☐ No

If yes, please specify below:

Miscarriages, how many? _____

Abortions, how many? _____

Have you had gestational diabetes in the past? ☐ Yes ☐ No

If yes, how did you manage your gestational diabetes then? ☐ Diet only ☐ Tablets ☐ Insulin

(*Continued on back*)

PATIENT LABEL

C. MEDICAL HISTORY

History of any of the following conditions? (*Check all that apply*)

- ☐ None
- ☐ PCOS (Polycystic Ovarian Syndrome)
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Heart Trouble
- ☐ Problems with blood sugar
- ☐ High cholesterol
- ☐ Stroke
- ☐ Stomach Ulcers
- ☐ Kidney Disease
- ☐ Gastric bypass surgery
- ☐ Cancer
- ☐ Liver Disease
- ☐ Gallbladder disorder / removal
- ☐ Thyroid Disease
- ☐ Anxiety/Depression
- ☐ HIV/AIDS
- ☐ Digestive Disorders
- ☐ Diverticular Disease
- ☐ Postpartum Depression

Do you take any of the following medications?

☐ Prenatal Vitamins ☐ Iron ☐ Other - Specify (name & dosage): _____

Did your healthcare provider limit the amount of physical activity you can do?

☐ Yes ☐ No If yes, why? _____

Patient/Legal Representative Signature: _____ Date: _____ Time: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

TO BE COMPLETED BY EDUCATOR

B/P:_____ P:_____ Wt: _____

Educator Signature: _____ Date: _____ Time: _____

INTERPRETER'S STATEMENT

The foregoing document was translated by the interpreter (listed below) to the patient or legal representative in the patient's or legal representative's primary language (indicate language): _____

He/she understood all of the terms and conditions and acknowledged his/her agreement with the above document.

☐ Interpreter Service (free of charge) – Interpreter Name and Identification Code: _____

☐ Offered Interpreter Service (free of charge); patient declined

☐ Family/Other used at patient's request - Interpreter Name and Relationship: _____

Witness: _____ Date: _____ Time: _____A.M./P.M.

PATIENT LABEL