

2010 California Diabetes & Pregnancy Program-Sweet Success Data Form

Site Information				Total Number of Sweet Success Visits	
Region		Affiliate		Face to Face	Phone
Satellite		Initials		Fax	Email
Maternal Information Demographic Data				Comment:	
Hispanic Origin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Race/Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Multiracial <input type="checkbox"/> Unknown					
Pre-pregnant Weight					
FOR PREGESTATIONAL DIABETES ONLY:				Maternal Outcome (select all that apply) <input type="checkbox"/> Unknown	
Date of preconception A1C				<input type="checkbox"/> Preterm Delivery (less than 37 weeks)	
Results (value)				<input type="checkbox"/> Term Delivery	
Date of first prenatal A1C				<input type="checkbox"/> Ante-partum hospitalization needed	
Results (value)				<input type="checkbox"/> Prolonged post-partum hospitalization due to complications of diabetes	
First Antepartum Sweet Success visit				<input type="checkbox"/> Maternal readmission within 28 days of delivery	
Date		Measured Height (Inches)		<input type="checkbox"/> Maternal death/cause of death _____	
Weight (lbs)		Estimated delivery date (EDD)		<input type="checkbox"/> Other _____	
Diabetes Diagnosis at first Sweet Success visit (check all that apply)				Pregnancy Outcomes <input type="checkbox"/> Unknown	
<input type="checkbox"/> Unknown				Date of Delivery _____	
<input type="checkbox"/> Pre-Diabetes prior to pregnancy				Mother's Age at Delivery _____	
<input type="checkbox"/> 1 abnormal value only				<input type="checkbox"/> Live birth	
<input type="checkbox"/> History of GDM				<input type="checkbox"/> Elective termination	
<input type="checkbox"/> GDM Date of diagnosis: _____				<input type="checkbox"/> Spontaneous abortion	
<input type="checkbox"/> Type 1 (DM1)				<input type="checkbox"/> Fetal death (20 weeks GA +)	
<input type="checkbox"/> Type 2 (DM2)				<input type="checkbox"/> Other (please specify) _____	
<input type="checkbox"/> Diagnosis with A1C during pregnancy				Multifetal <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
Treatment at First Sweet Success Visit <input type="checkbox"/> Unknown				Number (1)____ (2)____ (3 or more)____ <input type="checkbox"/> Unknown	
Check all that apply				Method of Delivery <input type="checkbox"/> Unknown	
<input type="checkbox"/> Diet and exercise				<input type="checkbox"/> Vaginal <input type="checkbox"/> VBAC	
<input type="checkbox"/> Diet and exercise plus medication				<input type="checkbox"/> Primary Cesarean <input type="checkbox"/> Repeat Cesarean	
<input type="checkbox"/> Oral medications				Newborn Outcomes: <input type="checkbox"/> Unknown	
<input type="checkbox"/> Glyburide <input type="checkbox"/> Metformin				Birth Weight (grams)	
<input type="checkbox"/> Other (please specify) _____				Gender : <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown	
<input type="checkbox"/> Insulin: <input type="checkbox"/> MDI <input type="checkbox"/> Pump				NICU Admission <input type="checkbox"/> Yes <input type="checkbox"/> No	
Prenatal Edinburgh Score _____				Congenital malformations <input type="checkbox"/> Unknown	
Last Sweet Success Visit Before Delivery				<input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____	
Date		Weight (lbs)		Discharged with mom <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Treatment at Last Sweet Success Visit <input type="checkbox"/> Unknown				Feeding on discharge: <input type="checkbox"/> Unknown	
Check all that apply				<input type="checkbox"/> Breast milk <input type="checkbox"/> Formula <input type="checkbox"/> Both breast milk and formula	
<input type="checkbox"/> Diet and exercise				For GDM Only Post-partum Follow-Up Diagnosis	
<input type="checkbox"/> Diet and exercise plus medication				<input type="checkbox"/> Unknown	
<input type="checkbox"/> Oral medications				<input type="checkbox"/> No diabetes detected	
<input type="checkbox"/> Glyburide <input type="checkbox"/> Metformin				<input type="checkbox"/> Impaired glucose tolerance (IGT)	
<input type="checkbox"/> Other (please specify) _____				<input type="checkbox"/> Impaired fasting glucose (IFG)	
<input type="checkbox"/> Insulin: <input type="checkbox"/> MDI <input type="checkbox"/> Pump				<input type="checkbox"/> Both IGT and IFG	
				<input type="checkbox"/> Type 2 (DM2)	
				<input type="checkbox"/> Not tested	
				<input type="checkbox"/> Other (please specify) _____	
				Postpartum Edinburgh Score _____	