

Date of visit: 04/2/2026

Source of information: self (reliable)

**S:**

S.A is a 34 year old female, G5P2022 at 37w6d gestation, who presents to the diabetic OBGYN clinic for prenatal follow up appointment of gestational DM class A2. Pt has a history of gestational DM in her previous 2 pregnancies. She is currently on 16 units of nightly NPH, increased from 14 units from previous visit on 3/26 due to continued elevated readings on fingerstick log. Also at her last visit, pt complained of generalized body aches and subjective fever. At that time, she reported her kids at home were sick with similar symptoms, but they tested negative for Flu and COVID. She was advised to rest, hydrate with water, take Tylenol as needed and follow up at her next scheduled visit, which is today. Currently, pt feels much better and denies fever, chills, body aches, GI or urinary symptoms. She denies vaginal bleeding, leakage of fluid, or contractions. Reports good fetal movement.

PMHx: gestational DM in previous (2) pregnancies

PSHx: none

PFHx: no significant family history

Allergies: no known drug, environmental, or food allergies.

Medications: insulin NPH 16 units injection nightly, ferrous sulfate 325 mg tablet every other day, prenatal multivitamin tablet once daily

OB history:

2 NSVD (2016, 2022) at QHC, no complications

1 induced abortion at 12 weeks in setting of Typhoid fever (2014)

1 spontaneous abortion in 1st trimester (2015)

Glucose log from previous visit (3/26/26) on 14 units nightly NPH:

Fasting glucose: 2/7 abnormal (28%)

After breakfast: 0/7 abnormal (0%)

After lunch: 1/7 abnormal (14%)

After dinner: 0/7 abnormal (0%)

Other previous labs:

GCT on 10/17/25: 190

GTT on 10/28/25: 88/196/157/86

HgA1C on 10/3/25: 5.6% → 5.3% on 11/13/25 → 5.5% on 12/18/25 → 5.4% on 1/22/26 → 5.7% on 2/19/26

03/26/26:

CBC within normal limits

Syphilis negative

HIV negative

GBS negative

Growth scan: fetal weight 6lb 7 oz 43%

**O:**

Vitals:

BP: 113/74 mmHg; Pulse: 96 BPM; RR: 20 breaths/minute, unlabored; T: 97.8°F; SpO2: 98% on RA

Physical exam:

General: 34 YOF who appears stated age, well appearing, well groomed, well nourished. Not in any acute distress.

Pulmonary: symmetrical expansion with respiration. No intercostal retractions, or tenderness. Breath sounds equal bilaterally. No rales, wheezes, or rhonchi auscultated.

CV: regular rate and rhythm. S1 and S2 heard. No murmur, thrills, or clicks.

Abdomen: gravid uterus, fundal height measured at 37 cm. No tenderness or guarding. No inguinal hernia. No palpable lymphadenopathy. Striae and linea nigra noted.

Labs/imaging:

Glucose log from current visit (4/2/26) on 16 units nightly NPH:

Fasting glucose: 1/7 abnormal (14%) at 99 (pt states she did not take insulin the night before)

After breakfast: 0/6 abnormal (0%)

After lunch: 1/5 abnormal (20%)

After dinner: 0/5 abnormal (0%)

Fetal Doppler: FHR of 130 BPM

Urine dipstick: trace blood

**A:**

Pt is a 34 YOF G5P2022 at 37w6d gestation with well controlled gestational DM on insulin who presents for routine prenatal follow up. Glucose logs are overall within target range after increase of insulin from 14 to 16 units. Pt complained of generalized body aches and subjective fever at last visit (3/26), but currently is asymptomatic with reassuring fetal status.

Ddx:

1. Pregestational Diabetes Mellitus

A. Pt has class A2 gestational diabetes which is a type of gestational DM that cannot be managed by lifestyle changes, and thus requires medication (insulin). She also has history of gestational DM in her previous 2 pregnancies, which raises concern for underlying type II DM. Recurrent GDM increases the likelihood of preexisting insulin resistance. However, her A1C levels have remained well controlled throughout pregnancy, making true pregestational DM less likely. Postpartum follow up and long term management is important in this patient.

2. Resolved viral illness

A. Pt previously reported subjective fever and body aches with sick contacts at home, suggesting a viral illness. Her symptoms have since resolved with rest, hydration, and Tylenol. A resolved viral illness in a pregnant patient is not very concerning, but supports a self-limited process. Unless symptoms recur, no further workup is necessary.

3. UTI

A. The presence of trace blood on urine dipstick raises concern for possible irritation from UTI although less likely given lack of leukocyte esterase and nitrites. Pregnant patients, especially those with diabetes, are at increased risk of UTIs due to urinary stasis and glycosuria. Although she denies urinary symptoms this is important to consider because untreated infection can progress to pyelonephritis.

**P:**

- Plan for induction of labor by 39w6d, to be scheduled at next visit (4/9/26)
- Non-stress test (NST) and biophysical profiles weekly
- Will get HgA1C and collect urine for culture today
- Advised to continue current DM medication (16 units nightly NPH) and to continue finger stick log
- Advised to continue prenatal vitamins and ferrous sulfate
- Encouraged patient to present to L&D triage if she experiences uterine contractions, leakage of fluid, vaginal bleeding or spotting, or decreased fetal movement. After hours, she was advised to call OB hotline at (888) 262-7435 for urgent questions/concerns

- Pt advised to return to clinic in one week. She expresses understanding.