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Nutrition Assessment Form

Gestational Diabetes

Name ____ DOB ____________ Date_________

Contact info (phone or e-mail) _______________________________

Medical Information

Height _______ Weight _______ Pre-Pregnancy weight _______

Estimated due date_________ How many weeks pregnant? ___________

I am pregnant with ❑ single baby ❑ twins ❑ triplets

Are you currently experiencing any of the following?

❑ Nausea ❑ Vomiting ❑ Diarrhea ❑ Constipation ❑ Loss of appetite Food aversions

Food cravings ________________________________ Food allergies ______________________________

Medications____

Vitamins and nutritional supplements ____

Please list any relevant medical conditions such as high blood pressure or high cholesterol:

____

Please list any family members or blood relatives with diabetes _________________________________

If you have been pregnant in the past, were you diagnosed with gestational diabetes? ❑ Yes ❑ No

Lifestyle Information

Are you currently exercising? ❑ Yes ❑ No

If yes, How often? ___________________________ Duration ____________ Type __________________

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

How many people in your household? ___________

Eating Patterns

Who does your cooking? ______________________ Who does your shopping? ____________________

How often do you eat out in a typical week? ______________________

How many meals do you eat in a typical day? _____________________

How often do you snack in a typical day? _________________________