Hunterdon Health
Center for Nutrition & Diabetes Management
Wescott Medical Arts Building
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Gestational Assessment

Please Fill Out in Pen. Do Not Use Pencil.

General Information

Name: ____________________________________Date of Birth:________________________________

OB/GYN:__________________________Primary Care Physician or other: ___________________________

For Instructor Use Only
BP:____________________ Date: ___________
BG:____________________
Meter: ______________________________ Time:____________

Medications - List all medications, vitamins, herbs and supplements, over the counter medications you are taking:

Name	Dose	When Taken	Taking it as prescribed? Yes/No

List any Food and/or Drug Allergies:____

What is your goal for this education session?____

____

1. Occupation: ______________________________________Work hours:__________________________
2. Last grade of school completed: ____
3. Is there anyone who will help you with managing your diabetes? ☐ Yes ☐ No
   If yes, who? ____
   List any family members with diabetes: ____
   ____
4. What is your expected delivery date?____
5. Do you have a history of gestational diabetes with prior pregnancies? ☐ Yes ☐ No
6. Pregnancy: ☐ First ☐ Second ☐ Third ☐ Fourth ☐ Other
7. Number of children:__________ Number of miscarriages/abortions:__________

Knowledge of Diabetes

1. In your own words,what is gestational diabetes? ____________________

____

2. What do you think caused your gestational diabetes? ____________________

____

3. How do you feel about having gestational diabetes? ____________________

____

4. How would you rate your understanding of gestational diabetes? ☐ Good ☐ Fair ☐ Poor

Learning Style

1. Do you prefer to learn by: ☐ Reading ☐ Discussion ☐ Internet ☐ DVD/CD ☐ Hands on training
2. Do you use a Smart Phone or Tablet? ☐ Yes ☐ No
3. If so, do you use nutrition or physical activity apps? ☐ Yes ☐ No
4. Which apps do you use? ____________________

____

Exercise

1. Do you exercise regularly? ☐ Yes ☐ No

   Type of exercise:____________________

   How often do you exercise? ____________________

   How long do you exercise? __________ What time of day do you exercise? __________

2. List any problems or limitations with exercise: (for example: bed rest)

____

Intake History

1. List any medical conditions:____________________
2. Date of last physical examination:____________________
3. Date of last eye exam:____________________
4. Date of last dental exam:____________________
5. Is your health important to you? ☐ All the time ☐ Sometimes ☐ Only when ill ☐ Not at all
6. Do you know how to check your blood sugar? ☐ Yes ☐ No
7. Have you ever tested your urine for ketones? ☐ Yes ☐ No
8. Do you smoke? ☐ Yes ☐ No If yes, how much?__________
9. Do you drink alcohol? ☐ Yes ☐ No If yes, amount and type:__________
10. Have you recently felt down, depressed, hopeless or have little or no interest/pleasure in doing things?

    ☐ Yes ☐ No

11. Are you being treated for depression? ☐ Yes ☐ No

Nutrition

Height:__________Weight:__________Pre-pregnancy Weight:__________

1. Who does the cooking?______________________________
2. How many milk or yogurt servings do you consume in one day? ____________________________

   Vegetable servings?______________________________

   Fruits Servings?______________________________

   Water Servings?______________________________
3. What are your main beverages?____
4. How many times a week do you eat away from home?_____________________________________
5. Type of meal when you eat away from home: ☐ Cafeteria style ☐ Diner ☐ Restaurant ☐ Fast food ☐ Other
6. How is your food usually prepared? ☐ Fried ☐ Baked ☐ Broiled ☐ Grilled ☐ Other
7. How would you best describe your appetite? ☐ Good ☐ Poor ☐ Excessive (large portions)
8. Do you: ☐ Eat unplanned meals ☐ Nibble between meals ☐ Have food cravings ☐ Skip meals ☐ Use convenience foods ☐ Eat rapidly ☐ Other
9. Do you have any religious or cultural observations that affect how you eat? ☐ Yes ☐ No

   If yes, explain:____
10. Are you having any problems with heartburn? ☐ Yes ☐ No
11. Are you having any problems with constipation? ☐ Yes ☐ No
12. Do you plan to breastfeed? ☐ Yes ☐ No

Patient Signature:____Date:_________________

Instructor Signature:______________________________________Date:_________________

Nutritionist Signature:_____________________________________Date:_________________

Please record a "usual" day. Include portions if known.

BREAKFAST Time__________	MORNING SNACK Time__________
LUNCH Time__________	AFTERNOON SNACK Time__________
DINNER Time__________	EVENING SNACK Time__________

______________________________ R.D. Date: ______________