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? _____

2. How long do you exercise? _____ What time of day do you exercise? _____
3. 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: