



# Center for Nutrition & Diabetes Management

HUNTERDON HEALTHCARE SYSTEM  
*The Heart of Modern Medicine*

WESCOTT MEDICAL ARTS CENTER  
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## Gestational Assessment

### General Information

Name: \_\_\_\_\_

<b>For Instructor Use Only</b>	Date: _____
BP: _____	
BG: _____	Date/Time: _____
Meter: _____	

1. Occupation: \_\_\_\_\_ Work hours: \_\_\_\_\_

2. Last grade of school completed: \_\_\_\_\_

3. Marital status:  Single  Married  Divorced  Widowed

4. Is there anyone who will help you with managing your diabetes?  Yes  No  
If yes, who? \_\_\_\_\_

5. List any family members with diabetes: \_\_\_\_\_

6. What is your expected delivery date? \_\_\_\_\_

7. Do you have a history of gestational diabetes with prior pregnancies?  Yes  No

8. Pregnancy:  First  Second  Third  Fourth

9. How many children do you have? \_\_\_\_\_

### 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

5. What is your goal for this education session? \_\_\_\_\_

**Medication**

1. List any medications you take. (Please list the name of the medication, the dose taken, and the time taken.)

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_

2. List any over the counter medications: \_\_\_\_\_  
\_\_\_\_\_

3. List any dietary or herbal supplements: \_\_\_\_\_  
\_\_\_\_\_

4. List any drug allergies: \_\_\_\_\_  
\_\_\_\_\_

**Exercise**

1. Do you exercise regularly?  Yes  No

- A. Type of exercise: \_\_\_\_\_
- B. How often do you exercise? \_\_\_\_\_
- C. How long do you exercise? \_\_\_\_\_ What time of day do you exercise? \_\_\_\_\_
- D. Do you know what your target heart rate should be?  Yes  No

2. List any problems with exercise: \_\_\_\_\_  
\_\_\_\_\_

**Medical History**

1. How often do you have a physical examination? \_\_\_\_\_ Date of last exam: \_\_\_\_\_

2. How often do you have your eyes checked? \_\_\_\_\_ Date of last exam: \_\_\_\_\_

3. How often do you have a dental checkup? \_\_\_\_\_ Date of last exam: \_\_\_\_\_

4. Have you been hospitalized within the last 12 months?  Yes  No  
If yes, describe reason(s): \_\_\_\_\_

5. Have you been to the Emergency Room within the last 12 months?  Yes  No  
If yes, describe reason(s): \_\_\_\_\_

6. How would you describe your general health?  Good  Fair  Poor

7. Is your health important to you?  All the time  Sometimes  Only when ill  Not at all

8. Do you know how to check your blood sugar?  Yes  No  
Have you ever tested your urine for ketones?  Yes  No

9. Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_

10. Do you drink alcohol?  Yes  No If yes, amount and type: \_\_\_\_\_

11. List any other medical conditions: \_\_\_\_\_  
\_\_\_\_\_

**Nutrition**

1. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pre-pregnancy weight: \_\_\_\_\_

2. Describe your typical diet:

Breakfast: \_\_\_\_\_ Time: \_\_\_\_\_  
Lunch: \_\_\_\_\_ Time: \_\_\_\_\_  
Dinner: \_\_\_\_\_ Time: \_\_\_\_\_  
Snacks: \_\_\_\_\_ Time: \_\_\_\_\_

3. Who does the cooking? \_\_\_\_\_

4. How much milk or yogurt do you consume in 1 day on average? \_\_\_\_\_

5. How many vegetables? \_\_\_\_\_

6. How many fruits? \_\_\_\_\_

7. Are you taking prenatal vitamins?  Yes  No

8. How many times a week do you eat away from home?

Type of meal when you eat away from home:

Cafeteria style  Diner  Restaurant  Fast food

9. How is your food usually prepared?  Fried  Baked  Broiled  Grilled

10. How would you best describe your appetite?  Good  Poor  Excessive (large portions)

11. Do you:  Eat unplanned meals  Nibble between meals  Have food cravings  
 Skip meals  Use convenience foods  Eat rapidly

12. List any food allergies: \_\_\_\_\_

13. Do you have any religious or cultural observations that affect how you eat?  Yes  No  
If yes, explain: \_\_\_\_\_

14. Are you having any problems with heartburn?  Yes  No

15. Are you having any problems with constipation?  Yes  No

16. Do you plan to breastfeed?  Yes  No

Patient Signature: _____	Date: _____
Instructor Signature: _____	Date: _____
Nutritionist Signature: _____	Date: _____