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

General Information

Name: ____

For Instructor Use Only 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. 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
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:_________________

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: _________________