DOHR, COLL & GADSON
OB/GYN ASSOCIATES & MEDICAL SPA
- We Offer Personalized Care For Women, By Women -

600 Hart Road., Suite 310 ▯ Barrington, IL 60010 847-304-0044 *healthcareforwomen.net*

Nutrition Assessment Form
Gestational Diabetes

Date _____ Name _____ Age/DOB _____

Contact info (phone or e-mail) _____

Medical Information

Height _____ Weight _____Pre-Pregnancy weight _____How many weeks pregnant? _____

Are you currently experiencing any of the following?

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Loss of appetite

Food aversions _____ Food cravings _____

Food allergies _____

Medications you are currently taking _____

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 exercising? ☐ Yes ☐ No How often? _____ Duration _____ Type_____

Do you drink alcohol? ☐ Yes ☐ No Do you 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 week/month? _____How often do you snack in a day?_____