

NOVAS, DOHR, COLL & GADSON
OB/GYN ASSOCIATES & MEDICAL SPA

- We Offer Personalized Care For Women, By Women -

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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? _____