NOVAS, DOHR, COLL
OB/GYN ASSOCIATES, S.C.

600 Hart Rd., Suite 310 • Barrington IL 60010
847 304-0044 • *www.NovasAssociates.com*

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? _____