LifeHelp Nutrition and Diabetes Center
Pregnancy Nutrition Assessment Form

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City/Zip: _____

Home Phone: _____ Other Phone: _____ Insurance: _____

Health History

When were you diagnosed with gestational diabetes? _____

Is this your first pregnancy? Yes ☐ No ☐ Second? ☐ Third? ☐ Other _____

Were you diagnosed with gestational diabetes in other pregnancies? (If applicable) _____

Have you ever received diabetes education before? _____

Please list any medical conditions: _____

Recent ER/hospital visits: When? _____Why? _____

Social History

Do you smoke? Yes ☐ (packs per day_____) Never ☐ Quit ☐ (When?_____)

Do you drink alcohol? Beer ☐ Wine ☐ Liquor ☐ How many times per week? _____

Does anyone provide you with practical and/or emotional support for managing your gestational diabetes? Yes ☐ No ☐
(Specify: _____)

Do you have any possible barriers to learning? Yes ☐ No ☐

Hearing: ☐ Visual: ☐ Language: ☐ Education: ☐ Other: ☐ (Specify: _____

_____)

Do you have financial concerns that affect your health care? Yes ☐ No ☐ (Explain: _____

_____)

Years of school completed: _____

Do you have any cultural or religious customs that may affect your diabetes care? Yes ☐ No ☐

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St. Petersburg, FL 33705
(727) 820-7910

St. Anthony's Hospital
BayCare Health System

LifeHelp

Blood Sugar Testing

Do you experience low blood sugar at times? Yes ☐ No ☐

Do you test your blood glucose at home? Yes ☐ No ☐ How often? _____

What type of meter do you use? _____

Do you have problems testing your glucose? No ☐ Yes ☐ (Please describe: _____

_____)

Nutrition History

Height: _____Pre-Pregnancy Weight: _____ Current Weight: _____

Are you following any meal plan at this time? No ☐ Yes ☐ Explain:_____

Who is responsible for most of the food shopping? _____ Cooking?_____

How often do you eat out? _____

Exercise Habits

Do you exercise? Yes ☐ No ☐ What type(s)? Walking ☐ Bicycling ☐ Swimming ☐ Other ☐

How many times per week do you exercise? 1-2 ☐ 3-4 ☐ 5-6 ☐ More than 6 ☐

How long do your exercise sessions last? _____

Do you have hypoglycemia (low blood sugar) during or following exercise? Yes ☐ No ☐

Have you ever been told by a physician to limit exercise? Yes ☐ No ☐

Do you have any conditions that prevent you from exercising? Yes ☐ No ☐

If yes, please describe: _____

_____

Do you have any chest discomfort when exercising? Yes ☐ No ☐

Do you have any immediate questions that you would like us to address today?

_____

_____

Patient Signature: _____ Date _____

Reviewed with patient by _____ Date _____