Northwestern Medicine®

Gestational Assessment Form

Patient information

Name: _____ Date: _____

Phone: _____ Cell: _____ Work: _____

Diabetes knowledge

How do you feel about having gestational diabetes? _____

_____

How would you rate how well you understand gestational diabetes? ..... ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your goal for this education session? _____

Nutrition

Have you gained 5 to 10 pounds in one month? ..... ☐ Yes ☐ No

Have you ever followed a meal plan? ..... ☐ Yes ☐ No

If yes, how many calories? _____

How many times do you eat per day? Number of meals _____ Number of snacks _____

Who does the cooking? _____

How many times a week do you eat away from home? _____

How would you describe your appetite? ..... ☐ Good ☐ Fair ☐ Poor

How does your mood or stress affect your eating? _____

Do you:
☐ Eat unplanned meals ☐ Nibble between meals ☐ Have food cravings
☐ Skip meals ☐ Use convenience foods ☐ Eat quickly

List any food allergies / intolerances: _____

Do you have any special dietary needs or religious observances? ..... ☐ Yes ☐ No

If yes, please explain: _____

Do you have heartburn? ..... ☐ Yes ☐ No

Do you have constipation? ..... ☐ Yes ☐ No

Medications

List any medications, supplements or herbs you take.

Name	Dose	Time you take it

Exercise

Are you physically active? . . . . . ☐ Yes ☐ No

If yes, what type of exercise: _____

How often? _____ How long? _____

List any problems with exercise: _____

Medical history

How often do you have physical examinations? _____ Date of last exam: _____

How often do you have your eyes checked? _____ Date of last eye exam: _____

How often do you have dental checkups? _____ Date of last dental visit: _____

Have you been hospitalized within the last 6 months? . . . . . ☐ Yes ☐ No

If yes, explain why: _____

Have you been to the emergency department within the last 6 months? . . . . . ☐ Yes ☐ No

If yes, explain why: _____

How would you describe your general health? . . . . . ☐ Good ☐ Fair ☐ Poor

Is your health important to you? . . . . . ☐ All the time ☐ Sometimes ☐ Only when ill ☐ Not at all

Do you currently smoke? Or have you ever smoked? . . . . . ☐ Yes ☐ No

If yes, for how long? _____ Cigarettes per day: _____ Quit date: _____

How often do you drink alcohol?

☐ Never/not during this pregnancy ☐ Once a month or less ☐ 2 to 4 times a month
☐ 2 or 3 times a week ☐ 4 or more times a week

How many drinks do you have on a typical day when you are drinking?
(A standard drink is a 12-ounce can of beer; a 5-ounce glass of wine; or a 1½-ounce shot of liquor.)

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

List any other medical conditions: _____

_____

Thank you for taking the time to complete this form.