Nutrition Assessment Form and Care Plan

Name: _____Contact No. _____Date: _____Age: _____ EDC: _____

Subjective

Medical history: _____

Obstetric history: _____

Smoking: _____ Alcohol: _____ Substance use: _____

Medications: _____

Appetite/ Recent changes: _____

GI discomforts: _____ Allergies/Intolerance: _____

Pica/Cravings/Aversions: _____ Food preferences: _____

Occupation/Educational level: _____ Hours worked/school: _____

Cultural/Religious influences: _____ Language: _____

Food Assistance (Food Stamps,WIC) : _____Financial situation: _____

Lives with: _____ Food preparer/purchaser: _____

Exercise: _____ Exercise restrictions: _____

Insulin therapy: _____

SMBG – Frequency: _____ Testing times: _____ Type of meter: _____

Infant feeding plans: Breast: _____ Bottle: _____ Undecided: _____

Objective

Gravida: _____ Para: _____ AB/Misc: _____ Week of gestation: _____

Wt: _____ Ht: _____ Prepregnancy wt: _____BMI: _____ Desirable wt: _____

Total wt gain: _____ Wt gain goals: _____

Lab Data: B/P: _____ Date: _____ Hgb:/Hct: _____Date: _____

Urine ketones: _____ Date: _____ OGCT: _____Date: _____

OGTT: _____ Date: _____

Adapted from American Dietetics Association Medical Nutrition Therapy Evidence based Guides for Practice: Nutrition Practice Guidelines for Gestational Diabetes Mellitus, American Dietetics Association 2001

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Food Plan Calculation

Visit No: _____

Food Group	B	S	L	S	D	S	Total Servings	Carbohydrate Grams	Protein Grams	Fat Grams	Energy Kcal
Starch											
Fruit											
Milk											
Vegetables											
Meat											
Fat											

Total energy intake = _____ kcal

Total carbohydrate _____ x 4 = _____ % kcal _____

Total protein _____x 4 = _____ % kcal _____

Total fat _____ x 9 = _____ % kcal _____

Requirements: Energy _____Carbohydrate _____Protein _____ Fat _____

Name of the Person Completing Form: _____

Adapted from American Dietetics Association Medical Nutrition Therapy Evidence based Guides for Practice: Nutrition Practice Guidelines for Gestational Diabetes Mellitus, American Dietetics Association 2001

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24 – Hour Food Recall

Name: _____ Date: _____

Please write down everything you ate and drunk yesterday from the time you woke up until the time you went to bed. Include all meals, snacks, and beverages and if you ate during the night.

Time	Type of Food or Beverage	Amount

Is this the way you usually eat? If not, what is the difference?

_____

_____

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Gestational Diabetes Blood Glucose and Food Record Form

Visit No: _____

Write down everything you eat, including the amounts and how the food was prepared.

Blood Test	Food/How Prepared	Amount	OFFICE USE ONLY					
			Carb					
Fasting: _____	**Breakfast:** Time:		Starch	Fruit	Milk	Veg.	Meat	Fat
After breakfast: _____	**Snack:** Time:							
After lunch: _____	**Lunch:** Time:							
	Snack: Time:							
After dinner: _____	**Dinner:** Time:							
	Snack: Time:							

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		Total						

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