



**GENERAL INFORMATION:**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_

Due Date: \_\_\_\_\_ Home: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Work: \_\_\_\_\_

Pre-Pregnancy Weight: \_\_\_\_\_ Number of years of school completed: \_\_\_\_\_

1. Is this a multiple pregnancy?  Yes  No  
 (IF YES):  Twins  Triples  Other: \_\_\_\_\_
2. Is this your first pregnancy?  Yes  No  
 (IF NO): How much weight did you gain during your last pregnancy? \_\_\_\_\_  
 Have you had gestational diabetes with a previous pregnancy?  Yes  No  
 (IF YES): How did you take care of it? \_\_\_\_\_
3. Have you had any complications with this pregnancy?  Yes  No  
 (IF YES, PLEASE EXPLAIN): \_\_\_\_\_
4. Do you plan to breastfeed your baby?  Yes  No
5. Are you taking a prenatal vitamin?  Yes  No
6. Are you taking any other vitamins or other mineral supplements?  Yes  No  
 (IF YES, PLEASE EXPLAIN): \_\_\_\_\_
7. Are you on any medication?  Yes  No  
 (IF YES, PLEASE LIST): \_\_\_\_\_
8. Medical History: Do you have any medical conditions?  Yes  No  
 (IF YES, PLEASE EXPLAIN): \_\_\_\_\_
9. Health Belief/Attitudes/Goals:  
 Feelings about diabetes \_\_\_\_\_  
 Goals for education session \_\_\_\_\_

**FOOD HABITS INFORMATION:**

1. Have you had any previous nutrition counseling?  Yes  No  
 (IF YES): A. Who provided the counseling?  
 (CHECK ALL THAT APPLY):  Registered dietitian  Physician  Nurse  
 Weight Counselor  Group weight reduction program  
 Other \_\_\_\_\_  
 B. What was the reason for the nutrition counseling? \_\_\_\_\_  
 C. What type of diet was prescribed? \_\_\_\_\_
2. In your household, who does the: Cooking? \_\_\_\_\_  
 Shopping? \_\_\_\_\_



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3. How is food typically prepared?  
 (CHECK ALL THAT APPLY):  Baked  Fried  Microwaved  Grilled  Other \_\_\_\_\_
4. How often do you eat out per week? Breakfast \_\_\_ Lunch \_\_\_ Dinner \_\_\_ Other \_\_\_
5. What types of restaurants do you usually frequent?  
 (CHECK ALL THAT APPLY):  Fast Food  Buffet/Salad Bar  Ethnic Foods  Other \_\_\_\_\_
6. Do you have any food allergies/intolerances?  Yes  No  
 (IF YES, PLEASE LIST): \_\_\_\_\_
7. Are there any foods you avoid for religious/cultural or philosophical reasons?  Yes  No  
 (IF YES, PLEASE LIST): \_\_\_\_\_
8. Do you use artificially sweetened products?  Yes  No
9. Do you drink alcohol?  Yes  No  
 (IF YES): What type? \_\_\_\_\_ How often? \_\_\_\_\_

**FOOD FREQUENCY:**  
 (PLEASE MARK THE NUMBER OF TIMES PER DAY OR WEEK THAT YOU EAT THESE FOODS)

FOOD ITEM	DAILY	WEEKLY	SELDOM	NEVER
MILK (check type of milk): <input type="checkbox"/> whole <input type="checkbox"/> 2% <input type="checkbox"/> 1% <input type="checkbox"/> ½% <input type="checkbox"/> skim				
YOGURT				
CHEESE OR COTTAGE CHEESE				
EGGS				
MEAT (CHICKEN, BEEF, TURKEY, PORK)				
LUNCHMEAT				
FISH				
PEANUT BUTTER				
POTATOES, RICE, NOODLES, BREAD				
WHOLE GRAINS				
CEREAL				
CHIPS, PRETZELS, POPCORN, SNACK CRACKERS				
COOKED VEGETABLES/RAW VEGETABLES/SALAD				
FRESH FRUIT				
CANNED FRUIT				
JUICE				
BUTTER/MARGARINE/SALAD DRESSING				
DESSERTS (COOKIES, CAKE, PIE, ICE CREAM, CANDY)				

Do you eat snacks during the day or at bedtime? If so, what do you eat? \_\_\_\_\_



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