Community Nutrition Services
Prenatal Background Questionnaire
Gestational Diabetes Management Program

Date: ____________________

Name: ____________________________________ Spouse's name: _________________________

Address: ____

Phone Number(s): Home: ______________________ Alternate: ______________________work/cell

Physician(s): ____

Age: ______ Date of Birth: ____/_____/_____ Due Date: ______________________________

Ht: _____'______" Pre-Pregnancy Weight: ________________________________

YOUR WEIGHT TODAY ON OUR SCALE: Weight: ____________

Number of years of school completed: _______ Primary Support Person: _______________________

Marital Status: (Circle One) Married / Single / Divorced / Widowed

Insurance: ________________________ Insurance ID #: ___________________________________

Occupation: ____________________________________ Work Hours: ________________________

1. At what hospital do you plan on delivering your baby?

   St. John's Mercy Medical Center ______ Other_____ (Where? _____________________________)

2. Is this a multiple pregnancy? Yes ________ No ________

   If yes: Twins ______ Triplets _______ Other (Please Specify) ______

3. Is this your first pregnancy? Yes ________ No ________

   If no: a) How many previous pregnancies? ________

   b) How many children do you have? ________ Ages: _____________________________

   c) How much weight did you gain in your last pregnancy? _________

   d) Have you had Gestational Diabetes with a previous pregnancy? ________
   If yes: What type of treatment was provided? ___________________________________

4. Have you had any complications with this pregnancy? Yes ________ No ________

   If yes, please explain: ____

5. Do you smoke? Yes ________ No ________

6. Do you plan to breastfeed your baby? Yes _________ No _________

7. Are you taking a prenatal vitamin? Yes _________ No _________

8. Are you taking any other vitamin, mineral, or herbal supplement? Yes _________ No _________

9. Are you on any medication? Yes _________ No _________ (If yes, please list) ______________________

____

10. How active are you?
    a. _________ No Regular Exercise
    b. _________ Exercise for about 20 minutes, once or twice a week
    c. _________ Exercise for about 20 – 30 minutes, 3 – 5 times a week
    d. _________ Exercise for more than 30 minutes, more than 4 times a week.
    e. _________ My doctor has restricted my activity during this pregnancy.

11. Health Status (Please Circle One) : Excellent / Good / Fair / Poor

12. Medical History: Do you have any medical conditions? Yes _________ No _________

    If yes, please explain: ____

    ____

13. Health Belief / Attitudes / Goals:

    Feelings about health: ____

    Feelings about diabetes: ____

    Goals for education session: ____

    ____

14. Do you have any trouble? Seeing _____ Hearing _____ Reading ___ Speaking English _____

    Other ____

15. Have you had any previous nutrition counseling? Yes _________ No _________

    If yes:
    a) Who provided the counseling?

    Registered Dietitian______ Weight Counselor______ Physician_______ Nurse_______

    Group Weight Reduction ______ (Please Specify): ________________________________

    Other: ____

    b) What was the reason for the nutrition counseling? _______________________

    ____

    c) What type of diet was prescribed? ____________________________________

16: In your household, who does the:

Cooking? ___________________________ Grocery Shopping? _______________________________________

17. How is food typically prepared? (Please circle all that apply)

Baked / Fried / Microwaved / Grilled / Other(s): ___________________________________

18. How often do you eat out during the week?

Breakfast _______ / Lunch_______ / Dinner _______ / Others_________________________________

19. What types of restaurants do you usually frequent? (Please circle all that apply)

Fast Food / Salad Bar-Buffets / Ethnic Foods / Others __________________________________

20. Do you have any food allergies /intolerances? Yes _________ No _________

If yes, please explain: ____

21. Are there any foods you avoid for religious, cultural, or philosophical reasons? Yes _______No ______

If yes, please explain: ____

22. Do you like milk? Yes _________ No _________

a) What kind do you usually drink? Fat-Free (Skim) _______ ½% _______ 1% _______ 2% ________ Whole ______ Chocolate _______

b) How many 8 ounce glasses of milk do you drink in a day? ________

INDICATE BELOW WHAT YOU EAT IN A TYPICAL DAY AND WHEN. INCLUDE MEALS, SNACKS, BEVERAGES, ETC.	
BREAKFAST TIME:	
SNACK: TIME:	
LUNCH TIME:	
SNACK TIME:	
DINNER TIME:	
SNACK TIME:	