

**NUTRITION HEALTH ASSESSMENT during pregnancy**

**NAME** (First, Last)

\_\_\_\_\_

**ADDRESS** (Street, City, State, Zip Code)

**HOME PHONE** ( ) \_\_\_\_\_

**E-MAIL** \_\_\_\_\_

**CELL** ( ) \_\_\_\_\_

**WORK** ( ) \_\_\_\_\_

**Profession:** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_

**Birthplace** \_\_\_\_\_

**HEIGHT** \_\_\_\_\_

**Sex** \_\_\_\_\_

**Pre-Pregnancy WEIGHT** \_\_\_\_\_

**Current WEIGHT** \_\_\_\_\_

How many weeks pregnant are you? \_\_\_\_\_

Which Trimester?      1<sup>st</sup> Trimester      2<sup>nd</sup> Trimester      3<sup>rd</sup> Trimester

**Referred By:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**PRIMARY PHYSICIAN** \_\_\_\_\_ **PHONE** \_\_\_\_\_

Reason for consultation: \_\_\_\_\_

**Medical history**

Do you have any of the following conditions? Please check all that apply.

- 1. Diabetes (Type I , II, or gestational) \_\_\_\_\_
- 2. Insulin resistance \_\_\_ Diagnosis date? \_\_\_\_\_
- 3. Heart disease \_\_\_ Please explain \_\_\_\_\_
- 4. High/low blood pressure \_\_\_\_\_
- 5. High cholesterol \_\_\_ High triglycerides \_\_\_
- 6. Overweight/obesity \_\_\_
- 7. Sleep apnea \_\_\_\_\_
- 8. GERD or reflux \_\_\_\_\_
- 9. Irritable bowel syndrome \_\_\_ Please explain \_\_\_\_\_
- 10. Diverticulosis \_\_\_\_\_
- 11. Stroke \_\_\_\_\_
- 12. Kidney disease \_\_\_\_\_
- 13. Cancer \_\_\_ Please explain \_\_\_\_\_
- 14. Mental illness \_\_\_ If yes, please explain \_\_\_\_\_
- 15. Eating disorder(s) or ED behaviors \_\_\_; Please explain \_\_\_\_\_

**Additional concerns:** \_\_\_\_\_

**Mindful Nutrition Counseling**  
 Office: 5061 North Pulaski Rd, Chicago, IL 60630  
 P: (773) 539-9364 \* Fax: (773) 539-0039  
[www.mindfulnutritionusa.com](http://www.mindfulnutritionusa.com)



**Do you have any food allergies or intolerances?**

If yes, please explain \_\_\_\_\_

**Have you used any fertility treatments/options?** Please describe. \_\_\_\_\_

**Family history**

Has anyone in your family been diagnosed with any of the diseases listed above?

**Medications**

Please list all medications you currently take: (dosage & time of day):

Please list all vitamins/minerals or herbal supplements you currently take:

**Current blood work** (Please provide most recent results, if known):

Blood sugar (fasting) \_\_\_\_\_ Hemoglobin A1c \_\_\_\_\_ Blood pressure: \_\_\_\_\_

Iron status \_\_\_\_\_ Thyroid (TSH): \_\_\_\_\_ Triglycerides: \_\_\_\_\_

Total cholesterol \_\_\_\_\_ LDL \_\_\_\_\_ HDL \_\_\_\_\_ Other \_\_\_\_\_

May we contact your Primary Care Physician to obtain blood work? \_\_\_\_\_

**Physical activity**

How frequently do you do you exercise?

Never \_\_\_\_\_ 1-2 x/wk \_\_\_\_\_ 3-4 x/wk \_\_\_\_\_ >4 x/wk \_\_\_\_\_

Average length of time?

<30 min \_\_\_\_\_ 30-60 min \_\_\_\_\_ >60 min \_\_\_\_\_

Please indicate the type of exercise(s) that you typically do:

Describe your workout intensity below: Light \_\_\_\_\_ Moderate \_\_\_\_\_ Vigorous \_\_\_\_\_

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**Eating habits**

Do you follow a special diet? Please explain.

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Please circle how many meals do you eat per day: 1 2 3 4 5 6 7 8

Please circle how many meals you eat per day on weekends: 1 2 3 4 5 6 7 8

Do you avoid any foods? \_\_\_\_\_

Why? \_\_\_\_\_

Do you have food cravings? \_\_\_\_\_

Do your eating habits change when stressed? \_\_\_\_\_

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Who does the grocery shopping \_\_\_\_\_; How often? \_\_\_\_\_

**Restaurant dining**

Please circle the number of days a week do you eat away from home: 1 2 3 4 5 6 7

What meals do you typically eat away from home?

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What are your favorite restaurants?

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**Lifestyle**

Are you a smoker? \_\_\_ Yes \_\_\_ No; If yes, how many cigarettes per day? \_\_\_\_\_

Do you drink alcohol? \_\_\_ Yes \_\_\_ No; If yes, how many drinks per week? \_\_\_\_\_

Please describe your caffeine intake: \_\_\_\_\_

**Personal concerns**

Would you like to change anything about your present lifestyle behavior(s)?

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Do you use stress reduction techniques? \_\_\_ Yes \_\_\_ No

What techniques do you (or have you) used? How often?

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What do you do for relaxation or enjoyment?

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On average, how many hours of sleep do you get per day? \_\_\_\_\_

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