Date: ­      Preferred name: ­

To make the most of your session, we ask that you please complete this form and email back to nde@vch.ca before your appointment. The information you provide will be kept confidential.

**Health History**

Expected due date:       Number of previous pregnancies:

Pre-pregnant weight:       Height:

Have you had any problems during this pregnancy? (e.g. nausea, high blood pressure, etc.)

Are you being treated for any other health problems? (e.g. arthritis, high blood pressure, etc.)

Does anyone in your family have diabetes? Yes [ ]  No [ ]  Don’t know [ ]  If yes, who?

Prenatal vitamin: Yes [ ]  No [ ]  Iron: Yes [ ]  No [ ]

Other vitamin/supplement(s):

Medication(s):

Do you have any allergies? Yes [ ]  No [ ]

If yes, please describe:

**Personal History**

Number of adults in household:       Number of children:       Ages of children:

What country were you born in?

What language do you speak at home?

**Employment**

Do you currently work? Yes [ ]  If yes, Full time [ ]  Part time [ ]  Casual [ ]  Shift work [ ]

No [ ]

What is your occupation?

Hours of work:

**Activity/Exercise**

What physical activities are you doing at present? (e.g. walking, swimming, etc.)

**Substance Use**

Have you used any alcohol, tobacco, marijuana, or other substances during your pregnancy? Yes [ ]  No [ ]

**Food History**

Have you changed your eating habits recently? Yes [ ]  No [ ]

If yes, please describe:

Do you follow any particular diet? Yes [ ]  No [ ]  If yes, please describe:

Do you have any food sensitivities? Yes □ No □ If yes, please describe:

Please check the meals and snacks that you would normally eat, and provide an example of the food(s) eaten:

[ ]  Breakfast:

[ ]  Morning Snack:

[ ]  Lunch:

[ ]  Afternoon Snack:

[ ]  Dinner:

[ ]  Evening Snack:

What would you like to learn or discuss at this session?