

# Gestational Diabetes Diet Plan

Patient Information	
Full Name:	
Date of Birth:	
Contact Number:	
Emergency Contact:	
Current Gestational Age:	
Pre-pregnancy Weight:	
Current Weight:	
Height:	
Blood Type:	
Date of Plan Initiation:	
Next Appointment:	

Dietary Assessment	
Typical Daily Food Intake:	
Known Food Allergies:	
Food Preferences:	
Physical Activity Level:	<input type="checkbox"/> Sedentary <input type="checkbox"/> Moderate <input type="checkbox"/> Active (Yoga & Walking)

Gestational Diabetes Diet Plan	
Total Daily Caloric Intake:	
Carbohydrates:	
Proteins:	
Fats:	
Fiber:	
Fluid Intake:	

<b>Meal Planning</b>	
Breakfast Options:	
Morning Snack Options:	
Lunch Options:	
Afternoon Snack Options:	
Dinner Options:	
Evening Snack Options:	

<b>Monitoring and Follow-Up</b>	
Blood Glucose Monitoring:	
Follow-Up Appointments:	
Additional Notes:	

<b>Healthcare Professional's Signature</b>	
Name:	
Signature:	
Date:	