

# Gestational Diabetes Diet Plan

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|--|--------------------------|
| Patient information  |                          |
| Full name:   | Date of birth:           |
| Emergency contact:   |                          |
| Current gestational age:   | Pre-pregnancy weight:    |
| Current weight:  | Height:                  |
| Blood type:  | Contact number:          |
| Next appointment:  | Date of plan initiation: |
| 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 and walking) |                          |
| Gestational diabetes diet plan   |                          |
| Total daily caloric intake:  |                          |
| Carbohydrates:   |                          |
| Proteins:  |                          |
| Fats:  |                          |
| Fiber:   |                          |
| Fluid intake:  |                          |
| Meal planning  |                          |
| 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 information</b> |  |
| Name and signature:                          |  |
| Date:  |  |