Prenatal Nutrition Assessment

Client ID: _____

ANTHROPROMETRIC

Weight Category: ___ Underweight ___ Normal ___ Overweight ___ Obese

___ Single ___ Twins

Weight gained during prior pregnancies: ___ pounds ___ N/A

BIOCHEMICAL

HGB: _____ HCT: _____

Fasting Blood Glucose: _____

Date of Consultation: _____

Other Labs: _____

Urine Analysis

Ketones: ___ / ___ Date: _____

Glucose: ___ / ___ Date: _____

Protein: ___ / ___ Date: _____

REFERRAL NEEDED?

Abnormal lab value? No ___ **Yes** ___

CLINICAL

Gravida: _____ Para: _____ Last pregnancy end-date: _____

Blood pressure: _____ Date: _____ Abnormal blood pressure? No ___ **Yes** ___

1. Are you experiencing any of the following discomforts? *(mark all that apply)* No ___ **Yes** ___

___ Nausea ___ Dizziness ___ Hemorrhoids ___ Leg Cramps

___ Vomiting ___ Diarrhea ___ Heartburn ___ Swollen Feet or Hands

___ Constipation ___ Gas ___ Other: _____

2. Do any of these discomforts keep you from eating as you normally would? No ___ **Yes** ___

If yes, explain: _____

3. Do any of the following apply to you? *(mark all that apply)*

___ Under 19 years of age ___ Currently breastfeeding another child

___ Anemia ___ Gastric Surgery ___ Teeth, gums, or mouth problems

___ Diabetes: ___ Type 1 ___ Type 2 ___ Gestational

___ Currently pregnant with multiples ___ Twins ___ Triplets or more No ___ **Yes** ___

___ Ever had a baby who weighed less than 5.5 pounds No ___ **Yes** ___

___ Ever had a baby who weighed more than 9 pounds No ___ **Yes** ___

___ Ever been told your unborn baby was not growing well No ___ **Yes** ___

___ Ever had an eating disorder (anorexia, bulimia, disordered eating) No ___ **Yes** ___

___ Ever had complications during a pregnancy No ___ **Yes** ___

___ Explain: _____

___ Other issues: _____ No ___ **Yes** ___

DIETARY

4. Are you currently taking any of the following?

Item	Which one(s)?	How much?	How often?	REFERRAL NEEDED?
Iron				Yes ___ **No** ___
Folic Acid				Yes ___ **No** ___
Prenatal vitamins				Yes ___ **No** ___
Other vitamins or minerals				Yes ___ **No** ___
Natural remedies or herbs				Yes ___ **No** ___
Liquid or powdered supplements				Yes ___ **No** ___
Laxatives				Yes ___ **No** ___
Prescription medication				Yes ___ **No** ___
Antacid				Yes ___ **No** ___
Over-the-counter medication				Yes ___ **No** ___

5. Are you allergic to any foods? No ___ **Yes** ___
   Explain: _____

6. Do you choose any of the following types of foods? *(mark all that apply)* No ___ **Yes** ___
   ___ Low in sugar ___ Low in fat ___ Low in salt ___ Vegetarian
   ___ Gluten-free ___ For weight loss ___ For weight gain ___ Other: _____

7. Do you eat from the following food groups? *(mark all that apply)* Yes ___ **No** ___
   ___ Eggs ___ Dairy ___ Poultry (fish)

8. If yes to questions 6 and 7, did anyone tell you to make these food choices?
   Explain: _____

9. Do you avoid any foods? No ___ **Yes** ___

10. If yes to question 9, why do you avoid these foods?
    ___ Do not like ___ Allergy ___ Intolerance ___ Other: _____

11. Do you ever eat any of the following foods: *(mark all that apply)* No ___ **Yes** ___
    ___ Unpasteurized milk or cheese
    ___ Shark, swordfish, king mackerel, or tilefish
    ___ Raw or undercooked eggs, meats, shellfish, or fish
    ___ Alfalfa/mung bean sprouts
    ___ Deli meat

12. Do you eat fish or shellfish from stores or restaurants more than twice per week? No ___ **Yes** ___

13. Do you eat fish caught locally (not store-bought) more than once per week? No ___ **Yes** ___

14. Do you eat or have you craved any of the following? *(mark all that apply)* No ___ **Yes** ___

___ Clay or dirt ___ Laundry starch ___ Ice or freezer frost
___ Cornstarch ___ Plaster or paint chips ___ Other non-food item: _____

15. Who buys the food where you live? ___ Myself ___ Other: _____

16. Who cooks the meals where you live? ___ Myself ___ Other: _____

17. In the past year, did you worry about running out of food? No ___ **Yes** ___

18. In the past year, did you run out of food and not have money to buy more? No ___ **Yes** ___

19. Do you receive WIC? Yes ___ **No** ___

20. Do you receive food stamps? Yes ___ **No** ___

21. Do you receive any free food services (food banks, pantries, or soup kitchens)? Yes ___ **No** ___

22. Do you have the following items at home? Yes ___ **No** ___

___ Oven ___ Electricity ___ Microwave
___ Stove ___ Refrigerator ___ Clean running water

23. Has your appetite been good since becoming pregnant? Yes ___ **No** ___

24. Have you had any changes in your eating habits since becoming pregnant? No ___ **Yes** ___
Explain: _____

25. Describe how you feel about the weight you have gained with this pregnancy:

_____

26. Have you fasted or do you plan to fast during this pregnancy? No ___ **Yes** ___

27. On an average day, do you spend over 2 hours watching television? No ___ **Yes** ___

28. On an average day, are you physically active for at least 30 minutes? Yes ___ **No** ___

29. Have you ever breastfed or tried to breastfeed? Yes ___ **No** ___

a. How long did you breastfeed? _____
b. Did you breastfeed as long as you wanted? _____
c. What was your experience like? _____

30. Is there anything that would prevent you from attempting to breastfeed? No ___ **Yes**___
Explain: _____

31. Who can you go to for breastfeeding help?

_____

32. Have you ever smoked cigarettes or used tobacco? No ___ **Yes** ___
a. If yes, when did you last smoke cigarettes or use tobacco? _____
b. If you smoke, how many packs of cigarettes do you smoke per day? _____
c. How interested are you in quitting smoking? 1___ 2___ 3___ 4___ 5___
Not interested — Very interested

33. Have you ever drank alcohol (beer, wine, wine coolers, hard liquor)? No___ **Yes**___
a. If yes, when did you last drink alcohol? _____
b. How much alcohol do you drink and how often? _____
c. How interested are you in quitting drinking? 1___ 2___ 3___ 4___ 5___
Not interested — Very interested

34. Have you ever used recreational drugs? No ___ **Yes** ___
a. If yes, which drugs did you use ? _____
b. When did you last use drugs? _____
c. If you use drugs, how much do you use and how often? _____
d. How interested are you in quitting drugs? 1___ 2___ 3___ 4___ 5___
Not interested — Very interested

_____ _____ _____
Assessor's Signature and Title | Date | Time Spent