Document Type: Forms/Other
Subject: Endo/Diabetes - Pregnancy Nutrition

MSC034

METHODIST PHYSICIANS CLINIC

NUTRITION DURING PREGNANCY ASSESSMENT RECORD

Please complete this form and bring it with you to your appointment or class.

1. Patient Information: Date:_____

Name: _____Age:_____Race:_____
Level of Education: _____Occupation: _____Work Hours:_____

2. Medical History:

Height:_____ Current Weight:_____ Weight before pregnancy:_____
Allergies:_____
Other medical problems: _____

3. Prenatal History:

Estimated Due Date:_____ Number of Weeks Pregnant:_____ Is this pregnancy twins or more? ☐ Yes ☐ No
Number of pregnancies including present pregnancy?_____ Number of living children:_____
Any complications during this pregnancy? ☐ No ☐ Yes, If yes, What? _____
Birth weight of child/children: #1_____ #2_____ #3_____ Etc._____

4. Exercise:

Do you currently have a regular exercise program? ☐ No ☐ Yes, if yes:

TYPE	LENGTH OF TIME	INTENSITY (circle)	# TIMES/WEEK
_____	_____	Light Medium Heavy	_____

Did you exercise prior to pregnancy? ☐ Yes ☐ No
Have you been advised by a medical provider to limit exercise in any way? ☐ No ☐ Yes
If yes, what are the limitations?_____

5. Social History:

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced
Number of people that live in household:_____ Relationship/s:_____
Are they supportive and helpful? ☐ Yes ☐ No
Are you delivering at Women's Hospital? ☐ Yes ☐ No
Tobacco History: ☐ Never Smoker ☐ Former Smoker ☐ Current Smoker

6. Medication: *Bring with you a list of all the medications you are currently taking, including over the counter (e.g. vitamins) OR list below:*

Medication	Dose	Times Taken

< over >

Patient Label
NAME:_____DOB:_____
FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

NMHS-2319
Rev. 5/2025

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7. Nutrition History:

Have you or are you currently following a special diet? ☐ No ☐ Yes, If yes explain:_____
Do you skip meals? ☐ No ☐ Yes, If yes which meals?_____
Do you cook at home? ☐ No ☐ Yes _____
Do you have any food allergies? ☐ No ☐ Yes, If yes, What:_____
Do you have any strong food dislikes? ☐ No ☐ Yes, If yes, What:_____
Do you have any food you would like included/cultural influences in your meal plan? ☐ No ☐ Yes
If yes, What:_____
How often do you eat out or pick up take out? ☐ Never ☐ 1-3 times/week ☐ 4-6 times/week ☐ Daily
When eating out where do you usually dine? ☐ Fast food ☐ Sit Down Restaurant ☐ Buffet
Do you plan to breast feed? ☐ Yes ☐ No

How often in the last month did you eat or drink the following?		Never	1-6/week	1-3/day	4 or more/day
Milk, yogurt, nut/soy milk, lactose free	☑ appropriate box				
Sweetened Drinks (Pop/Soda, energy drinks, juice)	☑ appropriate box				
Fruits (Fresh, frozen, canned, dried)	☑ appropriate box				
Starchy Vegetables (Corn, Potatoes, peas)	☑ appropriate box				

In the space provided below, record what you typically eat and drink, or what you have eaten in the past 24 hours. Include details such as type of food and amount of food in a day.

Example:	*Cereal-Cheerios - 1 Cup* *Milk – Skim - 1 Cup* *Toast - wheat 2 slices*
Meal Times	**Food Eaten and Amount**
Breakfast Time_____	
Snack Time_____	
Lunch Time_____	
Snack Time_____	
Dinner Time_____	
Snack Time_____	

What are you most interested in learning today?_____
_____
_____

Patient Label
NAME:_____DOB:_____
FIN:_____MRN:_____