



## 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: \_\_\_\_\_



**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	<input checked="" type="checkbox"/> appropriate box				
Sweetened Drinks (Pop/Soda, energy drinks, juice)	<input checked="" type="checkbox"/> appropriate box				
Fruits (Fresh, frozen, canned, dried)	<input checked="" type="checkbox"/> appropriate box				
Starchy Vegetables (Corn, Potatoes, peas)	<input checked="" type="checkbox"/> 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.**

Meal Times	Food Eaten and Amount
Example: Breakfast Time _____	Cereal-Cheerios - 1 Cup      Milk - Skim - 1 Cup      Toast - wheat 2 slices
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: \_\_\_\_\_