

Perinatal Food Group Recall

To be completed by a CPSP Practitioner while reviewing *MyPlate for Moms*

<http://www.cdph.ca.gov/programs/NutritionandPhysicalActivity/Documents/MO-NUPA-MyPlateForMoms.pdf>

On a typical day, how many servings of:

1. Fruit do you eat?

- 1 serving is:
- 1 cup or piece of fruit
 - 1/2 cup 100% fruit juice
 - 1/2 cup dried fruit

Never
Fewer than 2 servings/day
2 or more servings/day

1st Tri	2nd Tri	3rd Tri	Post
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Preferred fruits: _____

2. Vegetables do you eat?

- 1 serving is:
- 1 cup raw or cooked vegetables
 - 2 cups raw leafy greens

Never
Fewer than 3 servings/day
3 or more servings/day

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Preferred vegetables: _____

3. Milk Foods do you eat?

- 1 serving is:
- 1 cup milk or yogurt
 - 1 1/2 to 2 oz. cheese
 - 1 cup calcium fortified soy milk

Never
Fewer than 3 servings/day
3 servings/day*
More than 3 servings/day
*4 servings/day for teens

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Preferred milk foods: _____

4. Meat and Beans (Protein Foods) do you eat?

- 1 serving is:
- 1 oz. meat, fish or poultry
 - 1 egg
 - 1/2 oz. or small handful nuts
 - 1 tablespoon peanut butter
 - 2 tablespoons seeds, such as sunflower
 - 1/4 cup cooked dry beans, peas, lentils
 - 1/4 cup or 2 oz. tofu

Never
Fewer than 6 servings/day
6 - 7 servings/day
More than 7 servings/day

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Preferred protein foods: _____

Advise patient to:

- Aim for 2 or more servings/day.
- Eat a variety of fresh, frozen or canned fruits each day.
- Choose fresh, frozen and canned fruits without added sugars.
- Limit fruit juice.
- Aim for 3 or more servings/day.
- Eat a variety of fresh, frozen or canned vegetables without added sauces or salt.
- Choose some vegetables that are dark green or orange.
- Aim for 3 servings/day.
- Choose nonfat or low-fat (1%) milk.
- If patient does not use milk products, refer to *STT Do You Have Trouble with Milk Foods?* and *Foods Rich in Calcium*.
- Aim for 7 servings/day.
- Grill, broil or bake instead of fry.
- Take skin off poultry before/after cooking.
- Eat lean meat (15% fat or less).
- Eat 12 oz. of fish per week. Choose water-packed and low-mercury fish, e.g., canned light tuna
- Limit high-fat meats like sausage, hot dogs and bologna.
- If patient is vegetarian, review *STT "Vegetarian Eating."*

On a typical day:

5. How many servings of Grains do you eat?

- 1 serving is:
- 1 slice bread
 - 1 cup dry cereal
 - 1/2 cup cooked rice, pasta or hot cereal
 - 1 small corn or 1/2 small flour tortilla

- Never
Fewer than 6 servings/day
6-8 servings/day
More than 8 servings/day

1st Tri	2nd Tri	3rd Tri	Post
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name: _____

Advise patient to:	
<input type="checkbox"/>	Aim for 6-8 servings/day.
<input type="checkbox"/>	Avoid highly sweetened cereals.
<input type="checkbox"/>	Choose whole grains at least half of the time.
<input type="checkbox"/>	Use liquid oils from plants for cooking and in dressings.
<input type="checkbox"/>	Aim for 2 Tablespoons/day of oils like canola, olive or corn oil or soft tub margarine.
<input type="checkbox"/>	Avoid fried foods.
<input type="checkbox"/>	Bake, broil, steam, or microwave.
<input type="checkbox"/>	Avoid sugary drinks.
<input type="checkbox"/>	Aim for no more than 1 coffee drink per day.
<input type="checkbox"/>	Limit foods high in fat and sugar.
<input type="checkbox"/>	Choose low or non-fat products.
<input type="checkbox"/>	Choose fruits, vegetables, nuts and seeds as snacks.

6. Do you eat Whole Grains ?

- Whole grains include:
- Whole-grain bread, pasta or tortillas
- Brown rice, oatmeal (old fashioned, not instant)

Preferred whole grains: _____

Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Do you eat solid fats such as lard, stick margarine, butter or shortening?

Preferred healthy plant oils: _____

Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. How many cups of these beverages do you drink per day?

- Regular soda, fruit drinks or punch, sports drinks
- Caffeinated drinks like coffee, tea, soda or energy drinks

Preferred healthy beverages: _____

cups				
cups				

9. Do you eat these extra foods ?

- Candy, chocolate, chips, cookies
- Donuts, muffins, biscuits, cakes
- Ice cream, frozen yogurt
- Sour cream, mayonnaise

Preferred healthy snack foods: _____

Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the "Advise Patient to" Section, **check and date** items that the client is willing to improve/change. Incorporate this into the client's Individualized Care Plan.

	Signature	Title	Date	Time	NOTES:
1st Tri					
2nd Tri					
3rd Tri					
Post					