

PRENATAL NUTRITION ASSESSMENT

To be completed by a CPSP Practitioner

Age	Name
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Primary language? _____ English Fluency? Yes No Speak Read

ANTHROPOMETRIC

PLEASE REFER TO THE APPROPRIATE PRENATAL WEIGHT GAIN GRID

During previous pregnancies, how much weight did you gain? _____ pounds _____ N/A

BIOCHEMICAL

HGB or HCT (circle) _____ Date: _____		URINANALYSIS:		May Need Referral
Glucose Screen _____ Date: _____		Ketones: + / - Date: _____		
OTHER LABS (Please indicate): _____		Glucose: + / - Date: _____		
_____		Protein: + / - Date: _____		
		Abnormal Lab Value? <input type="checkbox"/> No <input type="checkbox"/> Yes		

CLINICAL

Gravida: _____ Para: _____

Date last pregnancy ended: _____

Blood Pressure: _____ Date: _____ Abnormal blood pressure? No Yes

1. Experiencing discomforts? No Yes
Mark all that apply:

<input type="checkbox"/> Nausea	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Swelling of feet or hands
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Leg cramps	
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Gas	<input type="checkbox"/> Constipation	<input type="checkbox"/> Other? _____

2. Do any of these discomforts keep you from eating as you normally would? No Yes
 If yes, please explain: _____

3. Do any of the following apply to you? Mark all that apply.

<input type="checkbox"/> Under 19 years of age	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Currently breastfeeding another child	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Teeth, gum, or mouth problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Gastric Surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Gestational	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Ever had a baby who weighed less than 5 1/2 pounds	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Ever had a baby who weighed more than 9 pounds	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Currently pregnant with multiples <input type="checkbox"/> Twins <input type="checkbox"/> Triplets or more	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Ever been told any of your unborn babies were not growing well	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Complications during a pregnancy (current or previous) Explain: _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Ever had an eating disorder (anorexia, bulimia, disordered eating)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Other issues or concerns (please describe): _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes

19. Do you receive Food Stamps? Yes No
20. Do you receive any free food services (food banks, pantries or soup kitchens?) Yes No
21. Do you have the following?
 Oven Electricity Microwave Have all of these Yes No
 Stove Refrigerator Clean running water
22. Has your appetite been good since becoming pregnant? Yes No
23. Have you had any changes in your eating habits since becoming pregnant? No Yes
If so, please describe: _____

24. Describe how you feel about the weight you have gained so far with this pregnancy.

25. Have you fasted during this pregnancy or do you plan to fast? No Yes
26. On an average day, do you spend over 2 hours watching TV? No Yes
27. On an average day, are you physically active for at least 30 minutes? Yes No
28. Have you ever breastfed or tried to breastfeed? Yes No
29. *If yes to Question 28, ask:* How long did you breastfeed? _____
 Did you breastfeed as long as you wanted? Yes No
 What was your experience like? _____
30. Is there anything that would prevent you from trying breastfeeding? No Yes
31. *If yes to question 30: Please explain.* _____
32. Who could you go to for breastfeeding help? _____
33. Have you ever smoked cigarettes or used tobacco? No Yes
34. *If yes to Question 33, ask:* When did you last use tobacco? _____
35. If you smoke, how many packs of cigarettes do you smoke per day? _____
 On a scale of 1 to 5, how interested are you in quitting? (circle)
 1 2 3 4 5
 No interest at all Very interested
36. Have you ever drank alcohol (beer, wine, wine coolers, hard liquor, etc.)? No Yes
37. *If yes to Question 36, ask:* When did you last drink alcohol? _____
38. If you drink alcohol, on a scale of 1 to 5, how interested are you in quitting? (circle)
 1 2 3 4 5
 No interest at all Very interested
39. Have you ever used street drugs such as marijuana, methamphetamine, cocaine, or heroin? No Yes
40. *If yes to Question 39, ask:* When did you last use? _____
 What did you use? _____
41. If you use street drugs, on a scale of 1 to 5, how interested are you in quitting? (circle)
 1 2 3 4 5
 No interest at all Very interested

Signature and Title	Date	Time to Complete
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