

**Pregnancy Health History and Nutrition Screening**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_

Prenatal Care or OBGYN: \_\_\_\_\_ Clinic: \_\_\_\_\_

Dentist: \_\_\_\_\_ Clinic: \_\_\_\_\_

**Insurance:**

None     Medicaid # \_\_\_\_\_     Private/HMO: \_\_\_\_\_

**Due Date:** \_\_\_\_\_ **Date of last Prenatal exam:** \_\_\_/\_\_\_/\_\_\_ **Date of last Dental exam** \_\_\_/\_\_\_/\_\_\_

How many pregnancies have you had prior to this one \_\_\_\_\_ # of living children/ages: \_\_\_/\_\_\_ \_\_\_/\_\_\_

History of Miscarriage or Still-birth:  Yes  No How far along in your pregnancy \_\_\_\_\_ weeks.

Type of complication:	Dates of pregnancy:	Bed rest needed? # of days needed?	Baby born at due date or premature?	Baby weighed?
1				
2				
3				
4				

Have you ever experienced a high-risk pregnancy  Yes  No

Has your Dr. shared concerns that this could be a high-risk pregnancy  Yes  No

Are you currently taking prenatal vitamins  Yes  No Are they prescribed by your Doctor  Yes  No

Names of prescription medications currently taking:	Names of over the counter medications currently taking:
1	1
2	2
3	3
4	4

	What:	How much/how often?	When?
Are you currently smoking?			
Are you currently drinking beer, wine or hard liquor?			
Are you being exposed to 2 <sup>nd</sup> or 3 <sup>rd</sup> hand smoke?			
Have you or are you using recreational or street drugs?			

Have you ever received treatment for substance abuse?  Yes  No

**Have you, or are you experiencing any of the following health concerns?**

	<u>History of:</u>	<u>Currently:</u>
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression or other Mental Health concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexually transmitted diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle Cell Trait / Disease (circle one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever received treatment from a Counselor or Mental Health Specialist?  Yes  No

**How many servings do you eat from the following food groups each day?**

Food Group	No	Yes	If yes, # of servings
Milk, Yogurt & Cheese Group			
Vegetable Group			
Fruit Group			
Meat, Poultry, Fish, Dry Beans, Eggs & Nuts Group			
Bread, Cereal, Rice and Pasta Group			
Fats, Oils and Sweets			
Water City water? _____ Well water? _____			
My favorite food is:			

Are you currently participating in WIC \_\_\_\_\_ Do you plan to breastfeed  Yes  No

Have you breastfed before  Yes  No Did you have trouble or concerns  Yes  No

If yes, what were your concerns \_\_\_\_\_

Would you like information about or support with breastfeeding  Yes  No

What did you weigh prior to pregnancy? \_\_\_\_\_ Height: \_\_\_\_\_ Current weight: \_\_\_\_\_

How often do you eat during the day? \_\_\_\_\_ times. Is this typical?  Yes  No

Are you avoiding or has your Dr. recommended you avoid any foods, and if so what foods \_\_\_\_\_

Have you, or have you had the desire to eat non-food items like clay, dirt, ice \_\_\_\_\_

Have you discussed physical activity with your doctor \_\_\_\_\_

What physical activity do you currently do \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_