

**Woman Nutrition Assessment**

Name \_\_\_\_\_ ID \_\_\_\_\_ EHS Parent Partner \_\_\_\_\_

Age _____	<b>PREG</b>	Ht (measured) _____ Prepreg Wt _____/BMI _____ Rec weight gain _____ EDD _____ Hgb/Hct _____ Date _____ Wks gest _____		<b>BF/PP</b>	Ht (measured) _____ Prepreg Wt _____/BMI _____ PP/BF Wt _____/BMI _____ Hgb/Hct _____ Date _____ 2nd BF Wt _____/BMI _____
<b>Weight Gain</b>	Date _____ Wt _____ wks gest. _____ total lbs gained _____ lbs/mo _____ WNL <input type="checkbox"/>		<b>Weight</b>	<input type="checkbox"/> Comfortable with current weight <input type="checkbox"/> Wt Goal: _____ Plan: _____ <input type="checkbox"/> Physically active Freq: _____ Type of exercise _____	<b>Notes: Visit 1</b> Topics Discussed: 1. _____ 2. _____ 3. _____ Mom's Plans: 1. _____ 2. _____ At Next Appt: Staff _____ Date _____
<b>Weight Management</b>	<input type="checkbox"/> Comfortable with recommended weight gain Efforts: _____ _____ lbs gained during last pregnancy ___ N/A <input type="checkbox"/> Physically active Freq: _____ Type of exercise _____	<b>Notes: Visit 1</b> Topics Discussed: 1. _____ 2. _____ 3. _____ Mom's Plans: Feeding Plan: <input type="checkbox"/> BF <input type="checkbox"/> FF 1. _____ 2. _____ At Next Appt: Staff _____ Date _____	<b>Diet</b>	<input type="checkbox"/> Changes in eating, how? _____ <input type="checkbox"/> Special diet/foods avoided _____ <input type="checkbox"/> Diet sheet used Comments: _____ Promotes positive eating habits: <input type="checkbox"/> Serves family meals <input type="checkbox"/> Plans and takes time to eat meals/snacks <input type="checkbox"/> Prepares a variety of foods for self and family	<b>Notes: Visit 2</b> Topics Discussed: 1. _____ 2. _____ 3. _____ Mom's Plans: 1. _____ 2. _____ At Next Appt: Staff _____ Date _____
<b>Diet</b>	<input type="checkbox"/> Changes in eating, how? _____ <input type="checkbox"/> Diet sheet used Comments: _____ <input type="checkbox"/> Cravings _____	<b>Notes: Visit 2</b> Topics Discussed: 1. _____ 2. _____ 3. _____ Mom's Plans: Feeding Plan: <input type="checkbox"/> BF <input type="checkbox"/> FF 1. _____ 2. _____ At Next Appt: Staff _____ Date _____	<b>Health</b>	<input type="checkbox"/> Folic Acid Source: <input type="checkbox"/> Supplement <input type="checkbox"/> Food Other vit./supp. _____ <input type="checkbox"/> Meds/Birth Control: _____ <input type="checkbox"/> C-section <input type="checkbox"/> Problem with healing Last dental visit: _____ <input type="checkbox"/> Decay <input type="checkbox"/> Bleeding gums Experiencing: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness Other: _____	<b>Notes: Visit 3</b> Topics Discussed: 1. _____ 2. _____ 3. _____ Mom's Plans: 1. _____ 2. _____ At Next Appt: Staff _____ Date _____
<b>Preterm Birth Risks</b>	<input type="checkbox"/> Taking prenatal vitamins _____ times/week <input type="checkbox"/> Other supp. _____ <input type="checkbox"/> Medications: _____ Experiencing: <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Swallowing <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness Other: _____ <input type="checkbox"/> Special Diet _____	<b>Notes: Visit 3</b> Topics Discussed: 1. _____ 2. _____ 3. _____ Mom's Plans: Feeding Plan: <input type="checkbox"/> BF <input type="checkbox"/> FF 1. _____ 2. _____ At Next Appt: Staff _____ Date _____	<b>Substance Use</b>	<input type="checkbox"/> Uses tobacco: <input type="checkbox"/> Wants and/or <input type="checkbox"/> Trying to quit Efforts: _____ <input type="checkbox"/> Exposed to second hand smoke <input type="checkbox"/> Uses alcohol <input type="checkbox"/> Around others who drink <input type="checkbox"/> Illicit drug use <input type="checkbox"/> Recovery Program	<b>Notes: Visit 4</b> Topics Discussed: 1. _____ 2. _____ 3. _____ Mom's Plans: 1. _____ 2. _____ At Next Appt: Staff _____ Date _____
<b>Other Fetal Risks</b>	<input type="checkbox"/> Uses tobacco: <input type="checkbox"/> Wants and/or <input type="checkbox"/> Trying to quit Efforts: _____ <input type="checkbox"/> Exposed to second hand smoke <input type="checkbox"/> Informed of smoking link to LBW and PTB Last dental visit: _____ <input type="checkbox"/> Decay <input type="checkbox"/> Bleeding gums	<b>Notes: Visit 4</b> Topics Discussed: 1. _____ 2. _____ 3. _____ Mom's Plans: Feeding Plan: <input type="checkbox"/> BF <input type="checkbox"/> FF 1. _____ 2. _____ At Next Appt: Staff _____ Date _____	<b>Breast Feeding</b>	Plans to bf until _____ <input type="checkbox"/> Return to work/school: <input type="checkbox"/> BF <input type="checkbox"/> FF <input type="checkbox"/> Both Current bf support person _____ B'ing is going: <input type="checkbox"/> great <input type="checkbox"/> need help <input type="checkbox"/> unsure B'milk supply is: <input type="checkbox"/> plentiful <input type="checkbox"/> adequate <input type="checkbox"/> low Pumps _____x/24 hr <input type="checkbox"/> electric <input type="checkbox"/> manual Experiencing: <input type="checkbox"/> sore nipples <input type="checkbox"/> cracked nipples <input type="checkbox"/> engorgement <input type="checkbox"/> any breast pain <input type="checkbox"/> Other Referred to: _____	<b>Notes: Visit 4</b> Topics Discussed: 1. _____ 2. _____ 3. _____ Mom's Plans: 1. _____ 2. _____ At Next Appt: Staff _____ Date _____
<b>Breast Feeding</b>	Knowledge & Perception _____ Support network _____ <input type="checkbox"/> Wants to learn more about BF	<b>Notes: Visit 4</b> Topics Discussed: 1. _____ 2. _____ 3. _____ Mom's Plans: 1. _____ 2. _____ At Next Appt: Staff _____ Date _____			