Woman Nutrition Assessment

Name _____ ID _____ EHS Parent Partner _____

Age _____

PREG

Ht (measured) _____ Prepreg Wt _____/BMI _____ Rec weight gain _____–_____

EDD _____ Hgb/Hct _____ Date_____ Wks gest _____

BF/PP

Ht (measured) _____ Prepreg Wt _____/BMI _____ PP/BF Wt _____/BMI _____

Hgb/Hct _____ Date_____ 2nd BF Wt _____/BMI _____

Weight Gain

Date _____ Wt _____ wks gest. _____ total lbs gained _____ lbs/mo _____ WNL Y N

Date _____ Wt _____ wks gest. _____ total lbs gained _____ lbs/mo _____ WNL Y N

Date _____ Wt _____ wks gest. _____ total lbs gained _____ lbs/mo _____ WNL Y N

Date _____ Wt _____ wks gest. _____ total lbs gained _____ lbs/mo _____ WNL Y N

Date _____ Wt _____ wks gest. _____ total lbs gained _____ lbs/mo _____ WNL Y N

Weight Management

Y N Comfortable with recommended weight gain

Efforts: _____

_____ lbs gained during last pregnancy ___ N/A

Y N Physically active Freq: _____

Type of exercise _____

Diet

Y N Changes in eating, how?_____

Y N Diet sheet used Comments: _____

Y N Cravings _____

Health

Y N Taking prenatals _____ times/week

Y N Other supp. _____

Y N Medications: _____

Experiencing: ☐ Heartburn ☐ Nausea ☐ Diarrhea ☐ Vomiting ☐ Constipation ☐ Swallowing ☐ Headaches ☐ Dizziness

Other: _____

Y N Special Diet _____

Preterm Birth Risks

Y N Uses tobacco: ☐ Wants and/or ☐ Trying to quit

Efforts: _____

Y N Exposed to second hand smoke

Y N Informed of smoking link to LBW and PTB

Last dental visit: _____ ☐ Decay ☐ Bleeding gums

Other Fetal Risks

Y N Uses alcohol Y N Around others who drink

Y N Informed of Fetal Alcohol Spectrum Disorder

Y N Illicit drug use Y N Recovery Program

Breast Feeding

Knowledge & Perception _____

Y N Support network _____

Y N Wants to learn more about BF

Notes: Visit 1

Topics Discussed:

1. _____
2. _____
3. _____

Mom's Plans: Feeding Plan: ☐ BF ☐ FF

1. _____
2. _____

At Next Appt:

Staff _____ Date _____

Notes: Visit 2

Topics Discussed:

1. _____
2. _____
3. _____

Mom's Plans: Feeding Plan: ☐ BF ☐ FF

1. _____
2. _____

At Next Appt:

Staff _____ Date _____

Notes: Visit 3

Topics Discussed:

1. _____
2. _____
3. _____

Mom's Plans: Feeding Plan: ☐ BF ☐ FF

1. _____
2. _____

At Next Appt:

Staff _____ Date _____

Weight

Y N Comfortable with current weight

Y N Wt Goal: _____ Plan: _____

Y N Physically active Freq: _____

Type of exercise _____

Diet

Y N Changes in eating, how?_____

Y N Special diet/foods avoided _____

Y N Diet sheet used Comments: _____

Promotes positive eating habits:

Y N Serves family meals

Y N Plans and takes time to eat meals/snacks

Y N Prepares a variety of foods for self and family

Health

Y N Folic Acid Source: ☐ Supplement ☐ Food

Other vit./supp. _____

Y N Meds/Birth Control: _____

Y N C-section ☐ Problem with healing

Last dental visit: _____ ☐ Decay ☐ Bleeding gums

Experiencing: ☐ Diarrhea ☐ Constipation ☐ Headaches ☐ Dizziness

Other: _____

Substance Use

Y N Uses tobacco: ☐ Wants and/or ☐ Trying to quit

Efforts: _____

Y N Exposed to second hand smoke

Y N Uses alcohol Y N Around others who drink

Y N Illicit drug use Y N Recovery Program

Breast Feeding

Plans to bf until _____

Y N Return to work/school: ☐ BF ☐ FF ☐ Both

Current bf support person _____

Bf'ing is going: ☐ great ☐ need help ☐ unsure

B'milk supply is: ☐ plentiful ☐ adequate ☐ low

Pumps _____ x/24 hr ☐ electric ☐ manual

Experiencing: ☐ sore nipples ☐ cracked nipples ☐ engorgement ☐ any breast pain ☐ Other

Referred to: _____

Notes: Visit 1

Topics Discussed:

1. _____
2. _____
3. _____

Mom's Plans:

1. _____
2. _____

At Next Appt:

Staff _____ Date _____

Notes: Visit 2

Topics Discussed:

1. _____
2. _____
3. _____

Mom's Plans:

1. _____
2. _____

At Next Appt:

Staff _____ Date _____

Notes: Visit 3

Topics Discussed:

1. _____
2. _____

Mom's Plans:

1. _____

At Next Appt:

Staff _____ Date _____

Notes: Visit 4

Topics Discussed:

1. _____
2. _____

Mom's Plans:

1. _____

Staff _____ Date _____

Nutrition Care Plan (SOAP Note Format)

Age_____	Age_____	Age_____
Staff _____ Date _____	Staff _____ Date _____	Staff _____ Date _____
Age_____	Age_____	Age_____
Staff _____ Date _____	Staff _____ Date _____	Staff _____ Date _____

Name_____ Birth Date _____

Physician _____ Dentist _____

- Health insurance: ☐ MaineCare ☐ None ☐ Other _____
- What services do you currently receive?
  ☐ TANF ☐ Food Stamps
  ☐ Home Visitation Program ☐ Public Health Nursing

	Yes	No
• Do you live in or spend time in a home built before 1978?	☐	☐
If yes, is the home being remodeled?	☐	☐
• Were there any days last month when your family did not have enough food to eat or enough money to buy food?	☐	☐
• Do you have problems refrigerating or heating/cooking your food?	☐	☐
• Do you feel unsafe for yourself or your children in your current relationship?	☐	☐
• Are you Hispanic or Latino?	☐	☐

- What best describes your race? **(check all that apply)**
  ☐ White ☐ American Indian or Alaska Native
  ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander

For those who have been pregnant before:

• Did you have problems during any pregnancy or delivery?	☐	☐
If yes, please explain? _____		
• Were any of your babies:		
stillborn?	☐	☐
born early/premature? If yes, how many weeks? _____	☐	☐
weigh 5 lb 8 oz or less at birth? If yes, what did your baby weigh? _____	☐	☐
weight 9 lb or more at birth? If yes, what did your baby weigh? _____	☐	☐

For those who have recently given birth:

• Did you have problems during this pregnancy or delivery?	☐	☐
If yes, please explain? _____		
• Over the past 2 weeks, have you ever felt down, depressed, or hopeless?	☐	☐
• Over the past 2 weeks, have you felt little interest or pleasure in doing things?	☐	☐

Office Use Only: Updated on _____ Staff initials _____ Updated on _____ Staff initials _____

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