

PRENATAL NUTRITIONAL ASSESSMENT

I routinely take vitamins/prenatal vitamins. Yes No

I routinely take herbal supplements. Yes No

I have food allergies. Yes No
 (Please list) _____

I routinely drink the following liquids:

a) Water	Yes	No
b) 100% fruit juice	Yes	No
c) Beverages with caffeine	Yes	No
d) Beverages without caffeine	Yes	No
e) Other _____		

I consume more than four servings/day of food with NutraSweet. Yes No

I skip meals or regularly go long periods of time without eating? Yes No

I have a history of:

a) Gestational diabetes	Yes	No
b) Anemia	Yes	No
c) Bulimia or anorexia	Yes	No
d) High blood pressure	Yes	No

I am currently having problems with the following:

a) Nausea and/or vomiting	Yes	No
b) Constipation or diarrheas	Yes	No
c) Leg cramps	Yes	No
d) Heartburn	Yes	No

I am having problems overeating/not eating enough (Please circle) Yes No

How many times a day do you consume one cup of milk? () 0-3

One cup of Yogurt, 2 ounces of hard cheese, or take Calcium supplement () 4+

I am a vegetarian. Yes No

I eat diary products, eggs, seafood (Circle any that apply)

I have specific concerns regarding my nutrition during this pregnancy. Yes No

Please explain: _____

Nursing Assessment of Nutritional Status	Consult sent? Yes No Date: _____
Please explain _____	
_____	_____
RN Signature	Date

 Patient Addressograph

