**Rock and Walworth Comprehensive Family Services, Inc.**

Head Start/Early Head Start

1221 Henry Avenue, Beloit WI 53511 P**hone:** (608) 299-1500 • **Fax:** (608) 299-1629

**Pregnancy Health History and Nutrition Screening**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **cc: \_\_\_\_\_\_\_\_\_\_\_\_\_**

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

Prenatal Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Insurance:**

None Badger Care/HMO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Private/HMO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last prenatal exam: \_\_\_/\_\_\_/\_\_\_ Date of last dental exam? \_\_\_/\_\_\_\_/\_\_\_

How many pregnancies have you had prior to this one? \_\_\_\_\_\_\_\_ Dates of last pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_

Number of children/ages: \_\_\_\_\_/\_\_\_\_\_\_\_\_Have you ever experienced a high-risk pregnancy? Yes No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 |  |  |  |  |

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 2nd hand smoke?** |  |  |  |
| **Have you or are you using recreational or street drugs?** |  |  |  |

Do you have allergies? Yes No Allergies to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**History of:** **Currently:**

Asthma □ Yes □ No □ Yes □ No

Ulcers or other stomach problems? □ Yes □ No □ Yes □ No

Diabetes? □ Yes □ No □ Yes □ No

Heart Problems? □ Yes □ No □ Yes □ No

High blood pressure? □ Yes □ No □ Yes □ No

Seizures? □ Yes □ No □ Yes □ No

Thyroid disease □ Yes □ No □ Yes □ No

Sexually transmitted diseases □ Yes □ No □ Yes □ No

Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Yes □ No □ 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: \_\_\_\_\_\_\_\_\_

Are you concerned about your weight? Yes No If so, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your appetite? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant Signature**: **Date:**