| 1. Last Name | First Name | MI |
|---|---|---|
| 2. Patient Number | | |
| 3. Date of Birth (MM/DD/YYYY) | Month / Day / Year | |
| 4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White | | |
| 5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported | | |
| 6. Gender ☐ Female ☐ Male | | |
| 7. County of Residence | | |

N.C. Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

# MATERNAL HEALTH HISTORY PART D NUTRITION SCREENING

*(See Instructions)*

Section A: TO BE COMPLETED BY PATIENT OR APPROPRIATE STAFF

1. Do you skip meals 5 or more times a week? ☐ No ☐ Yes
2. Are you lactose (milk) intolerant? ☐ No ☐ Yes
3. Do you have trouble getting food? ☐ No ☐ Yes
4. Do you want food or diet information? ☐ No ☐ Yes
5. How do you plan to feed your baby? ☐ Breastfeed ☐ Formula ☐ Undecided
   Did you have any problems breastfeeding your other child(ren)? ☐ No ☐ Yes ☐ N/A
   Have you had any breast surgery? ☐ No ☐ Yes
   Do you have any questions about breastfeeding? ☐ No ☐ Yes
6. Do you follow a special diet? ☐ No ☐ Yes; (list) ____________________
7. Do you ever want to eat anything that's not food: ice, clay, dirt, laundry starch, washing powder, paper, gravel?
   ☐ No ☐ Yes; (list) ____________________
8. Do you have any food allergies? ☐ No ☐ Yes; (list) ____________________
9. Do you now or have you ever had an eating disorder: severe pica, anorexia nervosa, bulimia, etc?
   ☐ No ☐ Yes; (list) ____________________
10. Have you had any obesity reduction procedures such as gastric bypass?
    ☐ No ☐ Yes; (list procedure & date) ____________________ (PATIENTS: PLEASE STOP HERE)

SECTION B: FOR STAFF USE ONLY:

**STAFF NOTES:**

____________________

____________________

____________________

____________________

____________________

Signature of Reviewer: ____________________ Date ____________

Interpreter Used: ☐ N/A ☐ No ☐ Yes Interpreter Name ____________________

The following conditions, based on documentation in the patient's medical record, may require a nutritionist referral:

| | | |
|---|---|---|
| Previous low birth weight infant | Pre-pregnancy underweight | Autoimmune disorder (lupus, etc) |
| Intrauterine growth restriction | Inadequate weight gain | Hgb<10 gm or HCT < 30% |
| Metabolic disorder (diabetes, PKU, thyroid dysfunction, etc.) | Substance abuse | Pre-pregnancy overweight |
| Chronic infection (HIV/AIDS, hepatitis, etc.) | Multiple fetuses | Excessive weight gain |
| | Maternal age 16 or younger | Medications, Herbal supplement use |

Referrals Made: ☐ Nutritionist / R.D. ☐ WIC ☐ Other: ____________________ Date ____________

## Instructions for Nutrition Risk Screening

Purpose: To identify the need for referral to the appropriate person/department/agency for follow-up.

Instructions: To indicate response to each risk screen item, place a check mark for No or for Yes.

- Staff notes can be used to elaborate on information obtained. Other needs or problems identified can be listed. If you use a progress note, write in this space.
- The staff reviewing the form must sign and date the form.
- Check off any referrals to any person/department/agency and record date referral made.
- Any concerns identified in section A requires appropriate follow up.
- Refer to the box (bottom of page) for conditions which may require a nutritionist referral.
- This form is to be kept with all the maternal health forms at all times.

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History.

Location: Go to the following link to access this form and print as needed:
http://whb.ncpublichealth.com/provPart/forms.htm