

MATERNAL HEALTH HISTORY
PART D
NUTRITION SCREENING
(See Instructions)

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

Section A: TO BE COMPLETED BY PATIENT OR APPROPRIATE STAFF

- Do you skip meals 5 or more times a week? No Yes
- Are you lactose (milk) intolerant? No Yes
- Do you have trouble getting food? No Yes
- Do you want food or diet information? No Yes
- 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
- Do you follow a special diet? No Yes; (list) _____
- Do you ever want to eat anything that's not food: ice, clay, dirt, laundry starch, washing powder, paper, gravel?
 No Yes; (list) _____
- Do you have any food allergies? No Yes; (list) _____
- Do you now or have you ever had an eating disorder: severe pica, anorexia nervosa, bulimia, etc?
 No Yes; (list) _____
- 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 _____

Referrals Made: Nutritionist / R.D. WIC Other: _____ Date _____

The following diagnoses 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 |

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 gray box for diagnoses 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>