

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)	Month	Day
		Year
4. Race <input type="checkbox"/> 1. White <input type="checkbox"/> 2. Black/African American <input type="checkbox"/> 3. American Indian/Alaska Native <input type="checkbox"/> 4. Asian <input type="checkbox"/> 5. Native Hawaiian/Other Pacific Islander <input type="checkbox"/> 6. Unknown		
Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
5. Gender <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female		
6. County of Residence		

## 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:**

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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                            | Substance abuse            | Pre-pregnancy overweight           |
| (diabetes, PKU, thyroid dysfunction, etc.)    | Multiple fetuses           | Excessive weight gain              |
| Chronic infection (HIV/AIDS, hepatitis, etc.) | 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>