MEDICAL RECORD - PRENATAL SOCIAL NEEDS AND NUTRITION ASSESSMENT

For use of this form, see MEDCOM Circular 40-16

This form is to be completed by the patient

Please answer the following questions. The information you provide will help us better plan your care. If you need help with the completion of this form, please ask any member of the staff.

SECTION I - PRENATAL SOCIAL NEEDS ASSESSMENT

1. **Marital status:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
2. **I live with my:** ☐ Husband ☐ Boyfriend ☐ Parents ☐ Roommate ☐ By myself
3. **Will your partner be deployed during your pregnancy?** ☐ Yes ☐ No ☐ Not applicable
4. **Will you be moving from this area during your pregnancy?** ☐ Yes ☐ No
   When? _____ Where to? _____
5. **I live in:** ☐ Base Housing ☐ BEQ/BOQ ☐ Apartment ☐ Home ☐ Other (please specify): _____
6. **I am happy with my living accommodations:** ☐ Yes ☐ No
7. **I have lived in the current area for:**
   ☐ Less than a month ☐ 1-6 months ☐ 7-12 months ☐ Over a year
8. **I have supportive family/friends in this local area:** ☐ Yes ☐ No
9. **My partner's response to this pregnancy:**
   ☐ Very supportive ☐ Somewhat supportive ☐ Not supportive ☐ Not applicable
10. **My primary means of transportation is:**
    ☐ Own car ☐ Partner's car ☐ Friend's car ☐ Public transportation
11. **My current financial status is:** ☐ Good ☐ Fair ☐ Poor
12. **If this pregnancy was unplanned, which of the following have you considered?**
    ☐ Keeping the child ☐ Adoption ☐ Abortion ☐ Foster placement
13. **This is my first pregnancy:** ☐ Yes ☐ No
14. **How many children live with you?** _____ **Children's ages:** _____
15. **What is your biggest concern right now?**

16. **How are you adjusting / dealing with this concern?**

17. **Please let us help you by sharing your concerns. Check any of the following areas in which you might need information / assistance:**

☐ Money	☐ Baby items
☐ Babysitting	☐ Legal assistance
☐ Career help	☐ Obtaining food
☐ Counseling	☐ Parenting classes
☐ Family planning	☐ Safety concerns
☐ Goal setting	☐ Transportation
☐ Housing	☐ Other (please specify): _____

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

SECTION II - PRENATAL NUTRITION ASSESSMENT

Your nutrition can have an important effect on your baby's health. Please answer these questions by checking the answers that apply to you.

Part A - DIET HISTORY

18. What was your weight before pregnancy? _____ **What is your weight today?** _____

19. Are you frequently bothered by any of the following? (Check all that apply)

☐ Nausea ☐ Vomiting ☐ Heartburn ☐ Constipation

20. Do you have children less than 12 months old? ☐ Yes ☐ No

If so, are you breast feeding? ☐ Yes ☐ No

21. Do you have food allergies or intolerances? ☐ Yes ☐ No

22. Are you a vegetarian? ☐ Yes ☐ No

23. How would you describe your eating habits? ☐ Very good ☐ Good ☐ Poor

24. Are you having any unusual cravings for non-food items? ☐ Yes ☐ No

25. Have you ever had an eating disorder such as bulimia or anorexia? ☐ Yes ☐ No

Part B - FOOD RESOURCES

26. Are you receiving any food assistance now? (Check all that apply)

☐ Donated food/commodities ☐ School breakfast ☐ School lunch ☐ WIC

☐ Food stamps ☐ Food pantry ☐ Soup kitchen ☐ Food bank

☐ Other (please specify): _____

Part C - FOOD and DRINK

27. What did you eat yesterday?

Food	Amount

28. What did you drink yesterday?

Beverage	Amount

29. Is the way you ate yesterday the way you usually eat? ☐ Yes ☐ No

Patient's Signature/Date

Provider's Signature/Date