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| --- | --- |
| **ANTHROPOMETRIC 🞎 WT. GRID PLOTTED**Wt. this visit: Weeks Gestation:Gain Since Last Visit: Total Wt. Gain:Comment: | Substance Abuse:12. Are you smoking at all? **Y N** If YES, how many cigarettes per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. How often do you drink beer, wine, or liquor? \_\_\_\_\_\_\_\_\_\_\_
2. What drugs have you used since becoming pregnant?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **BIOCHEMICAL****Blood Date Collected:**Hemoglobin:  **H L**  Hematocrit: **H L**MCV:  **H L**  Albumin: **H L**Glucose: **H L** GTT: **H L** | Labor and Delivery15. Have you had a hospital tour 🞎 Y 🞎 N16. Do you need information about what will happen during labor and delivery? 🞎 Y 🞎 N |
| **Urine Date Collected:**Glucose:  **+ -**  Protein: **+ -**Ketones: **+ -** | Health Education Goals: |
| **CURRENT CLINICAL**Blood Pressure: Edema:1. Scheduled test or procedures? **Y N**

 If **YES**, please list.1. Taking prenatal vitamins? **Y N**

 Iron? **Y N**1. Taking new medications or herbs? **Y N**

 If **YES**, please list?1. Significant changes since last assessment? **Y N**

 If **YES**, please explain.Clinical Update from previous visit: | **PSYCHOSOCIAL**1. Where are you living right now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How many people are living with you? \_\_\_\_\_\_\_\_\_\_\_
3. If you are worried about something,

 who do you talk to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_20. Do you have: 🞎 electricity 🞎 hot water 🞎 telephone🞎 transportation 🞎 heating 🞎 refrigerator 🞎 stove/oven1. Are you able to buy enough food? Y N
2. Are you able to pay your rent? Y N
3. Are you able to pay your other bills? Y N
4. How do you feel about this pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_
5. Since becoming pregnant, have you had? (✓ if yes)

🞎 trouble sleeping 🞎 sadness 🞎 worried feelings 🞎 crying 🞎 depression 🞎 sadness 🞎 none🞎 other\_\_\_\_\_\_\_\_\_\_\_\_\_\_26. Since becoming pregnant, have you been slapped, hit, or otherwise hurt by someone? If yes, by whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **NUTRITION**1. Have your eating habits changed since your last assessment? **Y N**

 If **YES**, please explain**Dietary Assessment 🞎 24 hour recall completed**Dietary Goals/Comments:Infant Feeding6. How do you plan to feed your baby?🞎 Breast 🞎 Bottle 🞎 Both 🞎 Not Sure7. Have you breastfed a baby before? Y N  If **YES**, how long did you breastfeed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **REFERRALS:** 🞎 WIC Date enrolled \_\_\_\_\_\_\_\_\_\_ Appointment Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Car Seat Class Date Attended \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other referrals 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_ 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**MATERIALS GIVEN:** 🞎 Family Planning 🞎 Infant Feeding 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ASSESSMENT SUMMARY:** |
| **HEALTH EDUCATION**8. Do you have an infant car seat? **Y N**9. Do you have a doctor for the baby? **Y N**10. Do you know what birth control you will use? **Y N**11. Have you receive counseling on HIV (AIDS)? **Y N** | **Reviewed By:****Next Assessment Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |