### 24 Hour Diet Recall

<table>
<thead>
<tr>
<th>Time</th>
<th>Amount</th>
<th>Food &amp; Drink</th>
<th>Fruits &amp; Vegetables</th>
<th>Breads, Grains, Cereals</th>
<th>Milk</th>
<th>PRO</th>
<th>Fats Other</th>
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#### Comments/Nutrition Goals:

**Dietary**

15. 24 Hour Diet Recall obtained above. ○ Y ○ N ............... 15. ○ Fwd STT N 21-28 Eating..., Food Intake & Recall
   ○ Ecld Daily Food Guide WIC or STT N 28 ..............
   ○ Ecld N HO-C ...........................................

16. How is your appetite? ________________________________ 16. ○ Fwd STT N 31-52 (Common discomforts)..............
   ○ Ecld N HO-D, E Nausea & Vomiting ..................
   ○ Ecld N HO-F, G Heartburn ..............
   ○ Ecld N HO-H, I Constipation .......................

#### ICP Interventions

17. How many cups of the following do you drink in a day? ............ 17. ○ Ecld
   ○ regular coffee ○ regular tea ○ sodas ○ milk ○ water

18. Are you allergic to any foods? ○ Y ○ N ............... 18. ○ Fwd STT N 53 Lactose Intolerance ..............
   ○ Ecld N HO-J, K .....................................
   ○ Ecld

19. Have you eaten or had cravings for any of the following: ......... 19. ○ Fwd STT N 79-80 Pica ..............
   ○ Ecld
   ○ dirt/clay ○ ice (more than 1 cup/day)
   ○ cornstarch ○ plaster ○ cigarette ashes
   ○ other:

20. Have your eating habits changed since you became ............... 20. ○ Ecld
    ○ pregnant? ○ Y ○ N ○ Describe: ____________________________

21. Total

22. WIC Recommendations

23. Evaluation

24. Patient Identification
### ICP Interventions

<table>
<thead>
<tr>
<th>Plan</th>
<th>(Developed in consultation with the patient.)</th>
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#### Nutrition Problems/Needs

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#### Health Practices

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#### Language/Education

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#### Health Education Assessment

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<table>
<thead>
<tr>
<th>21. Do you ever run out of food?</th>
<th>OY ON</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, how often?</td>
<td></td>
</tr>
<tr>
<td>Enrolled in WIC?</td>
<td>OY ON</td>
</tr>
<tr>
<td>Receive Food Stamps?</td>
<td>OY ON</td>
</tr>
<tr>
<td>22. Do you have a place to cook and refrigerate food?</td>
<td>OY ON</td>
</tr>
<tr>
<td>Describe:</td>
<td></td>
</tr>
<tr>
<td>23. How often do you exercise?</td>
<td></td>
</tr>
<tr>
<td>Type of exercise:</td>
<td></td>
</tr>
<tr>
<td>How long?</td>
<td></td>
</tr>
<tr>
<td>24. How are you going to feed your new baby?</td>
<td>OY ON</td>
</tr>
<tr>
<td>Breastmilk Formula Both Undecided Other</td>
<td></td>
</tr>
<tr>
<td>25. Have you ever breastfed before?</td>
<td>OY ON</td>
</tr>
<tr>
<td>How long? Why stopped?</td>
<td></td>
</tr>
<tr>
<td>26. How many years of education have you completed?</td>
<td></td>
</tr>
<tr>
<td>School/location?</td>
<td></td>
</tr>
<tr>
<td>Where?</td>
<td></td>
</tr>
<tr>
<td>27. Are you currently attending school?</td>
<td>OY ON</td>
</tr>
<tr>
<td>Where?</td>
<td></td>
</tr>
<tr>
<td>28. Do you plan to attend school after your baby’s birth?</td>
<td>OY ON</td>
</tr>
<tr>
<td>29. Which language do you prefer to read?</td>
<td>OY ON</td>
</tr>
<tr>
<td>English Spanish Cambodian Hmong Laotian None Other</td>
<td></td>
</tr>
<tr>
<td>30. How do you learn best? Reading Videos</td>
<td>OY ON</td>
</tr>
<tr>
<td>Classes/groups Individual teaching Other</td>
<td></td>
</tr>
<tr>
<td>31. Do you have any problems (hearing, seeing or reading)</td>
<td>OY ON</td>
</tr>
<tr>
<td>that make it hard for you to learn?</td>
<td></td>
</tr>
<tr>
<td>Describe:</td>
<td></td>
</tr>
<tr>
<td>32. Do you have any trouble attending appointments or classes?</td>
<td>OY ON</td>
</tr>
<tr>
<td>Describe:</td>
<td></td>
</tr>
<tr>
<td>33. Will you be able to get a car seat for your new baby</td>
<td>OY ON</td>
</tr>
<tr>
<td>Describe:</td>
<td></td>
</tr>
<tr>
<td>34. Do you wear a seat belt? OY ON</td>
<td></td>
</tr>
<tr>
<td>35. Is this your first experience with health care in the U.S. OY ON</td>
<td></td>
</tr>
<tr>
<td>Explain:</td>
<td></td>
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</table>
36. Have you had prior experience with and/or knowledge of pregnancy/postpartum issues?
   Prenatal care  Ø Y  Ø N  Delivery  Ø Y  Ø N
   PP self-care  Ø Y  Ø N  Infant care  Ø Y  Ø N
   Safety/injury prevention  Ø Y  Ø N
   Exposures: cat feces, hot baths, raw foods, X-rays, douches, mercury, pesticides  Ø Y  Ø N

37. Do you have any religious/cultural beliefs (e.g. fasting, …) that might affect your pregnancy?  Ø Y  Ø N

38. Who gives you the most advice about your pregnancy?  …………..

39. Have you taken any of these during this pregnancy?  …………..
   ○ prenatal vitamins/minerals
   ○ other vitamins/minerals (e.g. iron)
   ○ antacids (e.g. Tums, Mylanta, Alka Seltzer, Rolaid)
   ○ laxatives (e.g. Metamucil, Ex-Lax, Correctol, Fleet)
   ○ aspirin/ibuprofen compounds (Advil, Motrin, Alleve)
   ○ herbs: ginseng, ma huang (ephedra), hierba buena (spearmint), manzanilla (chamomile)
   ○ other:

40. How often do you brush/floss your teeth?  …………..

41. When did you last see a dentist?  …………..

42. What birth control method do you plan to use after this pregnancy?  …………..

43. Have you ever had a sexually transmitted infection:  …………..
   ○ gonorrhea, syphilis, chlamydia, or herpes?  Ø Y  Ø N
   If yes, explain:

44. Do you know/understand how HIV, the AIDS virus, is transmitted?  Ø Y  Ø N

45. What would you like more information about?  …………..
   ○ Danger signs
   ○ Preterm labor
   ○ Childbirth prep classes
   ○ Labor & Delivery
   ○ Hospital tour
   ○ Parenting classes
   ○ Newborn care
   ○ Family planning
   ○ Dental care
   ○ Pregnancy changes/fetal growth
   ○ Breastfeeding
   ○ Kick counts
   ○ Cats
   ○ Raw foods
   ○ Hot tubs
   ○ ESL classes
   ○ Other:

46. Have you had someone to assist you during this pregnancy with appointments, classes, L&D, etc.?  Ø Y  Ø N

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**ICP Interventions**

<table>
<thead>
<tr>
<th>Info</th>
<th>F/U</th>
<th>R</th>
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**300 Prenatal vitamins dispensed.**

**Date/signature**

- Prenatal vitamins dispensed.  Fwd STT N 71-72 Pn Vits/min.
- Ecd per HE HO-J, K, L
- Fwd STT HE 47-52 Oral Health During Pregnancy
- Ecd per HE HO-J, K, L
- Fwd STT HE 41-43 Workplace and Home Safety
- Ecd per HE HO-J, K, L
- Fwd STT HE 39-40 Cautions/Other Concerns
- Ecd per HE HO-J, K, L
- Fwd STT HE HO-H, I
- Ecd per HE HO-J, K, L
- Cautioned against aspirin/ibuprofen use
- F/U with practitioner.
- Fwd STT HE 47-52 Oral Health During Pregnancy
- Ecd per HE HO-J, K, L
- Fwd STT HE 41-43 Workplace and Home Safety
- Ecd per HE HO-J, K, L
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- Ecd per HE HO-J, K, L
- Cautioned against aspirin/ibuprofen use
- F/U with practitioner.

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**Testing offered/recommended**

- HIV and Pregnancy
- Ecd per HE HO-G
- Fwd STT HE 29-33 HIV and Pregnancy
- Ecd per HE HO-G
- Fwd STT HE 29-33 HIV and Pregnancy
- Ecd per HE HO-G
- Fwd STT HE 29-33 HIV and Pregnancy
- Ecd per HE HO-G
- Referral:

---

**Referral:***

- Other:

---

**Other:**

- Other:

---

**Referral:***

- Other:

---

**Referral:***

- Other:
**PSYCHOSOCIAL ASSESSMENT**

47. How do you feel about being pregnant? ○ Happy ○ Sad .................................................
   ○ Concerned ○ Excited ○ Other:

48. Is this pregnancy ○ Planned ○ Wanted .................................
   ○ Unplanned ○ Unwanted?

49. Have you been pregnant before? ○ Yes ○ No ...........................
   Experienced pregnancy or child loss? ○ Yes ○ No

50. Do any of your/your partner’s children live with someone else? ○ Yes ○ No

**Support System**

51. Who is going to help you with the pregnancy? ○ FOB .............
   ○ Your/his parents ○ Siblings ○ Friend ○ Other:

52. Who do you talk to when you have problems? ○ FOB ............
   ○ Your/his parents ○ Siblings ○ Friends ○ Other:

53. What is your relationship with the father of the baby? .............
   ○ Emotional support ○ Financial support ○ Not in contact
   ○ Other:

54. What are your sources of income assistance? ........................
   (Check all that apply) ○ TANF ○ Self-assistance
   ○ Self—work
   ○ Spouse/FOB—work
   ○ Friends ○ Family members
   ○ Other:

55. Is there anything at work or home that you worry about because you are pregnant (e.g., lifting heavy objects, chemicals, not enough breaks)? ○ Yes ○ No If yes, describe: .........................................

56. Do you plan to work after the baby is born? ○ Yes ○ No
   If yes, how soon after birth?

57. Is child care available for your new baby? ○ Yes ○ No
   ○ A Who?

**Stressful Life Event**

58. Have you ever received any counseling for emotional problems? ○ Yes ○ No Describe: ..........................................

59. Are you dealing with any of the following? (Check all that apply)
   ○ Recent death ○ Illness/Injury
   ○ Recent immigration ○ Separation/Divorce
   ○ Unemployment/Homeless ○ Legal problems
   ○ Child custody issues ○ Other:

---

**ICP Intervention**

54. ○ Fwd STT P 28-34 Financial Concerns ..............................
   ○ Referred to Social Services .................................

55. ○ Fwd STT HE 41-43 Workplace & Home Safety ............
   ○ Ecd per HE HO-I ..............................................

56. ..........................

57. ○ Referred to child care program: ................................
   ○ Referral: ......................................................

58. ○ Fwd STT P 73-76 Emotional/Mental Concerns ..............
   ○ Fwd STT P 77-81 Depression ..............................
   ○ Ecd per P HO-I ..............................................

59. ○ Fwd STT P 35-37 Legal/Advocacy Concerns ..............
   ○ Fwd STT P 38-43 New Immigrant ..........................

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**Health Education Problems/Needs**

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**Plan (Developed in consultation with the patient.)**

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**Patient Identification**
60. Do you have any of the following? (Check all that apply) ………
   ○ Experiencing mood swings
   ○ Having problems sleeping
   ○ Feeling anxious/nervous
   ○ Feeling sad, depressed
   ○ Feeling like there is no hope in your life
   ○ Feeling lonely, no one understands you
   ○ Thoughts of hurting self, unborn baby, or others
   ○ Other:

61. As a child or as an adult, have you ever been abused …………..
   physically, sexually or emotionally? ○ Y ○ N If yes, explain:

62. Are you in a relationship in which you have been …………..
   physically hurt or threatened by your partner? ○ Y ○ N
   Explain:

63. Where do you currently live? ○ Room ○ Apartment …. 
   ○ House ○ Group Home ○ Other:

64. Do you feel safe where you live? ○ Y ○ N If no, explain:

Substance Use
65. Have you ever smoked: ○ N ○ Y drunk alcohol: ○ N ○ Y 
   used street drugs: ○ N ○ Y (Name drug/s, when)

66. Since the start of this pregnancy have you used the 
   following?
   Tobacco: ○ N ○ Y Last use? How much?
   Alcohol: ○ N ○ Y Last use? How much?
   Street drugs: ○ N ○ Y Last use? How much?

67. Are you around people who smoke? ○ Y ○ N If yes, …………..
   describe:

Pregnancy Concerns
68. Do you have any concerns about having a baby? 
   (e.g. L&D, infant care, etc.) ○ Y ○ N Explain:

69. What are your goals/hopes for this pregnancy? …………..

Psychosocial Problems/Needs

Plan (Developed in consultation with the patient.)

Signature/title: ____________________ Title: ____________ Date: ____/____/____ Time in minutes: ____________

Signature of supervising physician: ____________________ Date: ____/____/____