|  |  |
| --- | --- |
| **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 Delivery  15. Have you had a hospital tour 🞎 Y 🞎 N  16. 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/oven   1. 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 Feeding  6. How do you plan to feed your baby?  🞎 Breast 🞎 Bottle 🞎 Both 🞎 Not Sure  7. 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |