Mercy Hospital St. Louis
Nutrition Services

Mercy Dietitian Services
Prenatal Background Questionnaire

Date: _____ Name: _____ Spouse's name: _____

Phone Number(s): Home: _____ Alternate: _____ work/cell

Referring Physician: _____

Age: _____ Date of Birth: _____/_____/_____ Due Date: _____

Ht: _____'_____" Pre-Pregnancy Weight: _____

YOUR WEIGHT TODAY ON OUR SCALE: Weight: _____

Number of years of school completed: _____ Primary Support Person: _____

Marital Status: (Circle One) Married / Single / Divorced / Widowed / Domestic Partnership

Occupation: _____ Work Hours: _____

1. Is this a multiple pregnancy? Yes _____ No _____

   If yes: Twins _____ Triplets _____ Other (Please Specify) _____

2. Is this your first pregnancy? Yes _____ No _____

   If no: a) How many previous pregnancies? _____

   b) How many children do you have? _____ Ages: _____

   c) How much weight did you gain in your last pregnancy? _____

   d) Have you had Gestational Diabetes with a previous pregnancy? _____

   If yes: What type of treatment was provided? _____

3. Have you had any complications with this pregnancy? Yes _____ No _____

   If yes, please explain:_____

4. Do you smoke? Yes _____ No _____

5. Do you plan to breastfeed your baby? Yes _____ No _____

6. Are you taking a prenatal vitamin? Yes _____ No _____

7. Are you taking any other vitamin, mineral, or herbal supplements? Yes _____ No _____

8. Are you on any medications? Yes _____ No _____ (If yes, please list) _____

   _____

9. How active are you?
   a. _____ No Regular Exercise
   b. _____ Exercise for about 20 minutes, once or twice a week
   c. _____ Exercise for about 20 - 30 minutes, 3 - 5 times a week
   d. _____ Exercise for more than 30 minutes, more than 4 times a week.
   e. _____ My doctor has restricted my activity during this pregnancy.

10. Health Status (Please Circle One): Excellent / Good / Fair / Poor

11. Medical History: Do you have any medical conditions? Yes _____ No _____

    If yes, please explain: _____

    _____

12. Health Belief / Attitudes / Goals:

    Feelings about health: _____

    Feelings about diabetes: _____

    Goals for education session: _____

    _____

13. Do you have any trouble? Seeing _____ Hearing _____ Reading _____ Speaking English _____

14. What is your language preference? Spoken_____ Reading _____

15. Do you need assistance in walking or standing? Yes _____ No _____

    If yes, please explain: _____

16. Do you feel that you are at risk for mental or physical harm/abuse? Yes _____ No _____

    If yes, please explain: _____

    _____

17. Have you had any previous nutrition counseling? Yes _____ No _____

    If yes:

    a) Who provided the counseling?

       Registered Dietitian _____ Weight Counselor _____ Physician _____ Nurse _____

       Group Weight Reduction _____ (Please Specify): _____

       Other: _____

    b) What was the reason for the nutrition counseling? _____

       _____

    c) What type of diet was prescribed? _____

18. In your household, who does the cooking? _____

19. How is food typically prepared? (Please circle all that apply)

    Baked / Fried / Microwaved / Grilled / Other(s): _____

20. How many meals do you eat per day? _____ Snacks? _____

21. How many times during the week do you eat out? _____

22. How would you describe your portions? _____ Small _____ Average ____ Large

23. Do you consider yourself a healthy eater? _____ Junk food eater?_____

24. Do you have any food allergies/intolerances? Yes _____ No _____

    If yes, please explain: _____

25. Are there any foods you avoid for religious, cultural, or philosophical reasons? Yes _____ No _____

    If yes, please explain: _____

26. Do you like milk? Yes _____ No _____

    a) What kind do you usually drink? Fat-Free (Skim) _____ 1%_____ 2% _____ Whole _____

       Chocolate _____ Other: _____

    b) How many 8 ounce glasses of milk do you drink in a day? _____

INDICATE BELOW WHAT YOU EAT IN A TYPICAL DAY AND WHEN. *(Include Meals, Snacks, Beverages, Etc. Or Attach Food Records.)*	
BREAKFAST	
TIME:	
SNACK	
TIME:	
LUNCH	
TIME:	
SNACK	
TIME:	
DINNER	
TIME:	
SNACK	
TIME:	