



Community Nutrition Services Prenatal Background Questionnaire

Date: _____

Name: _____ Spouse's name: _____

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

Physician(s): _____

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

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

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

Insurance: _____ Insurance ID #: _____

Occupation: _____ Work Hours: _____

1. At what hospital do you plan on delivering your baby?
St. John's Mercy Medical Center _____ Other _____ (Where? _____)
2. Is this a multiple pregnancy? Yes _____ No _____
If yes: Twins _____ Triplets _____ Other (Please Specify) _____
3. Is this your first pregnancy? Yes _____ No _____
If no: a) How many previous pregnancies? _____
b) How many children do you have? _____
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? _____
4. Have you had any complications with this pregnancy? Yes _____ No _____
If yes, please explain: _____
5. Do you smoke? Yes _____ No _____
6. Do you plan to breastfeed your baby? Yes _____ No _____
7. Are you taking a prenatal vitamin? Yes _____ No _____
8. Are you taking any other vitamin, mineral, or herbal supplement?
Yes _____ No _____
9. Are you on any medication? Yes _____ No _____

10. How active are you?
- _____ No Regular Exercise
 - _____ Exercise for about 20 minutes, once or twice a week
 - _____ Exercise for about 20 – 30 minutes, 3 – 5 times a week
 - _____ Exercise for more than 30 minutes, more than 4 times a week.
 - _____ My doctor has restricted my activity during this pregnancy.
11. Have you had any previous nutrition counseling? Yes _____ No _____
12. Have you been on any weight loss program? Yes _____ No _____
Please Specify: _____
13. In your household, who does the:
Cooking? _____ Grocery Shopping? _____
14. How is food typically prepared? (Please circle all that apply)
Baked / Fried / Microwaved / Grilled / Other(s): _____
14. How often do you eat out during the week?
Breakfast _____ / Lunch _____ / Dinner _____ / Others _____
15. What types of restaurants do you usually frequent? (Please circle all that apply)
Fast Food / Salad Bar- Buffets / Ethnic Foods / Others _____
16. Do you have any food allergies /intolerances? Yes _____ No _____
If yes, please explain: _____
17. Are there any foods you avoid for religious, cultural, or philosophical reasons?
Yes _____ No _____
If yes, please explain: _____
18. Do you like milk? Yes _____ No _____
- What kind do you usually drink? Fat-Free (Skim) _____ ½% _____ 1% _____
2% _____ Whole _____ Chocolate _____
 - How many 8 ounce glasses of milk do you drink in a day? _____
- 19) Do you use artificially sweetened products? Yes _____ No _____
- If yes, what brand: _____
 - How many servings per day? : _____
- 20) Do you drink alcohol? Yes _____ No _____
- If yes, what type? _____
 - How often? _____

INDICATE BELOW WHAT YOU EAT IN A TYPICAL DAY AND WHEN. INCLUDE MEALS, SNACKS, BEVERAGES, ETC.

BREAKFAST TIME:	
SNACK: TIME:	
LUNCH TIME:	
SNACK TIME:	
DINNER TIME:	
SNACK TIME:	