Tell Us About Yourself

Your Name_____ **Age** _____ **Date** _____

All Women

1. **My appetite is** ☐ great ☐ good ☐ fair ☐ poor

2. **I eat** _____ **number meals and** _____ **number snacks on most days.**

3. **I eat away from home, including restaurants, fast food, at work, at school** _____ **number of meals per week.**

4. **I may <u>not</u> eat enough of the following foods:**

   ☐ milk, yogurt, cheese
   ☐ protein foods: beef, chicken, pork, fish, eggs, beans
   ☐ fruits
   ☐ vegetables
   ☐ bread, cereal, rice, pasta, tortillas
   ☐ other_____

5. **I drink:** ☐ milk ☐ juice ☐ tea ☐ coffee ☐ soda ☐ ice tea ☐ sports drinks ☐ energy drinks ☐ other _____

6. **I eat:** ☐ swordfish ☐ locally caught fish ☐ white tuna ☐ none of these foods

7. **I take:** ☐ medications ☐ vitamins ☐ iron ☐ herbs ☐ a special diet ☐ none

8. **I have:** ☐ a medical problem ☐ had recent surgery or hospitalization ☐ food allergies ☐ food intolerances ☐ a dental problem such as: ☐ tooth loss ☐ bleeding gums ☐ tooth decay ☐ none of these issues

9. **I have a health concern with this or previous pregnancies or deliveries.** ☐ Yes ☐ No

   If yes, check all that are true.

   ☐ multiple pregnancy ☐ high blood pressure
   ☐ premature birth ☐ gestational diabetes
   ☐ delivered a baby, weighing less than 5½ pounds
   ☐ C-section ☐ still birth

10. **What nutrition or health issue would you like to talk about at today's visit?** _____

    _____

If you are pregnant

1. **I plan to gain** _____ **pounds with this pregnancy.**

2. **Are you concerned with weight gain?** ☐ Yes ☐ No

3. **I am having a problem with:**

   ☐ nausea ☐ constipation
   ☐ vomiting ☐ diarrhea
   ☐ heartburn ☐ no problems

4. **Since being pregnant I have had changes in my:**

   ☐ appetite ☐ food cravings
   ☐ food likes ☐ food dislikes
   ☐ cravings for non-food items like lots of ice, baking soda, clay, or cornstarch ☐ no changes

5. **I eat or drink the following foods or beverages:**

   ☐ luncheon meats
   ☐ raw or uncooked: meat, fish or eggs
   ☐ feta cheese
   ☐ unpasteurized juice ☐ raw milk
   ☐ none of these

6. **I plan to** breastfeed my baby.

   ☐ yes ☐ no ☐ maybe

If you have had your baby

1. **I feel that my weight is** ☐ too little ☐ OK ☐ too much.

If you are breastfeeding

1. **How is breastfeeding going?**

   ☐ great ☐ good ☐ fair ☐ poor

2. **I want to breastfeed up to:**

   ☐ 3 months ☐ 6-9 months
   ☐ 3-6 months ☐ the first year

Other Information

1. **I feel…….. Check any that describe you at this time.**

   ☐ happy ☐ OK ☐ tired ☐ down ☐ stressed
   ☐ other _____

2. **Do you sometimes run out of money or food stamps to buy food?** ☐ Yes ☐ No

3. **Would you like more information about community resources for you and your family?** ☐ Yes ☐ No

Tell Us About Your Wonderful Baby

Your Baby's Name _____ **Age** _____ **Date** _____

All babies

1. **My baby is** ☐ breastfed only ☐ formula fed only ☐ both breastfed and formula fed
2. **Is your baby eating anything besides breastmilk or formula?** ☐Yes ☐No
3. **My baby drinks from a:** ☐ bottle ☐ sippy cup ☐ cup ☐ none of these at this time
4. **What do you put in your baby's bottle?** _____
5. **When my baby is fed she is most often in:** ☐ someone's arms ☐ bed or crib ☐ carseat ☐ high chair ☐ stroller
6. **After feeding, what do you do with any formula or breastmilk left in the bottle?** _____
7. **My baby has** ☐ medical problems ☐ recent surgery ☐ hospitalizations ☐ food allergies ☐ food intolerances ☐ none of these
8. **My baby takes** ☐ vitamins _____ ☐ minerals ☐ medications ☐ other _____ ☐ none of these

If your baby is breastfed

1. **In a usual day, how often does your baby nurse?** _____
2. **How many "wet" diapers per day?** _____
3. **How many "soiled" diapers per day?** _____

For babies who eat other foods

1. **My baby eats _____ number of meals and _____ number of snacks each day.**
2. **My baby:** ☐ feeds himself ☐ is fed by someone
3. **What textures of food does your baby eat?**
   ☐ pureed ☐ lumpy ☐ chopped ☐ soft pieces
4. **My baby eats:**
   ☐ cereal ☐ fruits ☐ veggies ☐ meats
   ☐ juice ☐ cheese ☐ yogurt ☐ hot dogs
   ☐ crackers ☐ cookies ☐ desserts
   ☐ jarred foods ☐ homemade baby foods
   ☐ table foods ☐ finger foods ☐ milk
   ☐ raisins ☐ peanut butter ☐ honey
   ☐ popcorn ☐ grapes ☐ hard candy ☐ nuts
   ☐ other:_____

If your baby is using any formula

1. **What formula do you use?** _____
2. **What kind of water do you use to mix the formula?**
   ☐ well water ☐ bottled water ☐ public or city water
3. **My baby drinks** _____ number of bottles **in 24 hours** with _____ ounces in each bottle.

Other Information

1. **Parent's Measurements:** mother* or father: what is your height: _____ and weight*: _____
   *(Mothers use pre-pregnancy weight for this baby.)
2. **Does your family sometimes run out of money or food stamps to buy food?** ☐ Yes ☐ No
3. **Would you like more information about community resources for you and your family?** ☐ Yes ☐ No
4. **What nutrition or health issues would you like to talk about today?**
   _____
   _____

Thank you!

Tell Us About Your Wonderful Child

Your Child's Name_____ **Age** _____ **Date** _____

1. **My child's appetite is** ☐ great ☐ good ☐ fair ☐ poor

2. **My child eats** _____ number of meals per day
_____ number of snacks per day

3. **My child drinks** ☐ milk ☐ juice ☐ water
☐ other drinks: _____

4. **My child uses a** ☐ cup ☐ sippy cup ☐ pacifier ☐ bottle

5. **My child feeds himself or herself** ☐ Yes ☐ No

6. **My child may <u>not</u> eat enough of the following foods:**

☐ milk, yogurt, cheese
☐ protein foods like:
beef, chicken, pork, fish, eggs, beans
☐ fruits
☐ vegetables
☐ bread, cereal, rice, pasta, tortillas
☐ other_____

7. **Check any of the following foods that your child eats:**

☐ raisins ☐ peanut butter ☐ popcorn ☐ grapes
☐ hard candy ☐ nuts ☐ hot dogs
☐ none of these foods

8. **Does your child eat anything that is not food like: paper, crayons, paint chips, or clay?**

☐ Yes ☐ No

9. **Does your child eat the same foods as the rest of the family?**

☐ always ☐ sometimes ☐ rarely

10. **Do you make special foods or meals for your child?** ☐ Yes ☐ No

11. **In a typical week, how many meals does your child eat away from home at:**

_____ restaurants
_____ fast food
_____ child care or Head Start
_____ family or friends
_____ none of these

12. **My child has**
☐ a medical problem
☐ had recent surgery or hospitalizations
☐ food allergies
☐ food intolerances
☐ none of these

13. **My child takes** ☐ medication(s) ☐ a special diet ☐ vitamins ☐ minerals ☐ fluoride ☐ none of these

14. **My child has problems with his or her teeth?**
☐ Yes ☐ No

15. **My child has gone to the dentist?** ☐ Yes ☐ No

Other Information

1. **Parent's Measurements: mother* or father**
What is your height:_____ and weight*:_____

(Mothers use pre-pregnancy weight if you have had a baby in the last year or are now pregnant.)

2. **Do you sometimes run out of money or food stamps to buy food?** ☐ Yes ☐ No

3. **Would you like more information about community resources for you and your family?** ☐ Yes ☐ No

4. **What nutrition or health issues would you like to talk about today?**

_____

_____

Thank you!