1. Last Name	First Name	MI

2. Patient Number										

3. Date of Birth (MM/DD/YYYY)	Month	Day	Year

4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White

5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported

6. Gender ☐ Female ☐ Male

7. County of Residence

N.C. Department of Health and Human Services
Division of Public Health
Women Infant and Community Wellness Section

MATERNAL HEALTH HISTORY
PART D
NUTRITION SCREENING

(See Instructions)

Section A: TO BE COMPLETED BY PATIENT OR APPROPRIATE STAFF

1. Do you skip meals 5 or more times a week? ☐ No ☐ Yes
2. Are you lactose (milk) intolerant? ☐ No ☐ Yes
3. Do you have trouble getting food? ☐ No ☐ Yes
4. Do you want food or diet information? ☐ No ☐ Yes
5. How do you plan to feed your baby? ☐ Breastfeed ☐ Formula ☐ Undecided

   Did you have any problems breastfeeding your other child(ren)? ☐ No ☐ Yes ☐ N/A

   Have you had any breast surgery? ☐ No ☐ Yes

   Do you have any questions about breastfeeding? ☐ No ☐ Yes
6. Do you follow a special diet? ☐ No ☐ Yes; (list) _____
7. Do you ever want to eat anything that's not food: ice, clay, dirt, laundry starch, washing powder, paper, gravel?
   ☐ No ☐ Yes; (list) _____
8. Do you have any food allergies? ☐ No ☐ Yes; (list) _____
9. Do you now or have you ever had an eating disorder: severe pica, anorexia nervosa, bulimia, etc?
   ☐ No ☐ Yes; (list) _____
10. Have you had any obesity reduction procedures such as gastric bypass?
    ☐ No ☐ Yes; (list procedure & date) _____ (PATIENTS: PLEASE STOP HERE)

SECTION B: FOR STAFF USE ONLY:

STAFF NOTES:

_____

_____

_____

_____

_____

Signature of Reviewer: _____ Date _____

Interpreter Used: ☐ N/A ☐ No ☐ Yes Interpreter Name _____

The following conditions, based on documentation in the patient's medical record, may require a nutritionist referral:

Previous low birth weight infant	Pre-pregnancy underweight	Autoimmune disorder (lupus, etc)
fetal growth restriction	Inadequate weight gain	Hgb<10 gm or HCT < 30%
Metabolic disorder	Substance use	Pre-pregnancy overweight
(diabetes, PKU, thyroid dysfunction, etc.)	Multiple fetuses	Excessive weight gain
Chronic infection (HIV/AIDS, hepatitis, etc.)	Maternal age 16 or younger	Medications, herbal supplement use

Referrals Made: ☐ Nutritionist / R.D. ☐ WIC ☐ Other: _____ Date _____

Instructions for Nutrition Risk Screening

Purpose: To identify the need for referral to the appropriate person/department/agency for follow-up.

Instructions: To indicate response to each risk screen item, place a check mark for No or for Yes.

- Staff notes can be used to elaborate on information obtained. Other needs or problems identified can be listed. If you use a progress note, write in this space.
- The staff reviewing the form must sign and date the form.
- Check off any referrals to any person/department/agency and record date referral made.
- Any concerns identified in section A requires appropriate follow up.
- Refer to the box (bottom of page) for conditions which may require a nutritionist referral.
- This form is to be kept with all the maternal health forms at all times.

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History.

Location: Go to the following link to access this form and print as needed:
https://wicws.dph.ncdhhs.gov/provPart/forms.htm