PERINATAL DIET QUESTIONNAIRE

Participant's Name: _____ Date of Birth: _____ /_____ /_____

Pregnancy Due Date: _____ /_____ /_____

1. How are you feeling about this pregnancy?_____
2. When was your first prenatal visit for this pregnancy?_____
3. What was your weight before you became pregnant?_____
4. How much weight have you been advised to gain?_____
5. Have you ever had, or do you now have, a health or medical condition such as asthma, diabetes, depression, epilepsy, etc.?
   - ☐ No
   - ☐ Yes* If yes, please describe: _____
6. Do you take any of the following? (check all that apply)
   - ☐ Prenatal Vitamin
   - ☐ Multi-vitamin
   - ☐ Herbs or herbal remedies
   - ☐ Children's Vitamin
   - ☐ Iron
   - ☐ Medication: _____
   - ☐ None of these
7. What are your thoughts about breastfeeding?
   - ☐ Good idea, I plan to exclusively breastfeed my baby
   - ☐ Not sure, I would like more information
   - ☐ I plan to both breastfeed and formula feed my baby
   - ☐ I plan to feed my baby formula
8. Do you ever drink wine, beer or liquor?
   - ☐ No
   - ☐ Yes* date of last alcoholic drink _____
   - ☐ I would like to quit*
9. What best describes your smoking history?
   - ☐ Never smoked
   - ☐ Smoked, but I quit on _____ (month and year)
   - ☐ Currently smoke: _____ (# of cigarettes per day)*
   - ☐ I would like to quit*
10. Does anyone else living in your household smoke inside the home?
    - ☐ No
    - ☐ Yes*
11. Since you have been pregnant, have you taken any other drug(s) such as meth, crack, cocaine or marijuana?
    - ☐ No
    - ☐ Yes*
    - ☐ I would like to quit*
12. Have you seen a dentist during this pregnancy?
    - ☐ Yes
    - ☐ No, I would like to find a dentist*

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13. Do you have a cavity to be filled or tooth to be pulled?
    - □ No
    - □ Yes*

14. Check any of the following that you are experiencing:

□ Feeling sick to my stomach	□ Constipation	□ Eating all the time
□ Throwing up	□ Food cravings	□ No appetite
□ Heartburn	□ Diarrhea	□ Cravings for non-food items*
		□ None of the above

15. Are you following a prescribed special diet, weight control diet, vegan or macrobiotic way of eating?
    - □ No
    - □ Yes* If yes, please describe: _____

16. How many times a day do you usually eat? _____# meals per day _____ # snacks per day

17. How would you describe your appetite? □ Good □ Fair □ Poor

18. Do you ever drink raw/un-pasteurized milk or juice?
    - □ No
    - □ Yes*

19. Do you eat fish more than 2 times a week?
    - □ No
    - □ Yes*

20. Do you eat soft cheeses, such as feta, or raw cheeses?
    - □ No
    - □ Yes*

21. Which group of foods below do you find most challenging to eat enough of?

□ Milk, yogurt, cheese	□ Protein foods like: meat, fish, eggs, beans
□ Fruits	□ Vegetables
□ Bread, cereal, rice, pasta	□ Other: _____

22. How would you describe your daily activity? (check one)
    - □ Very active (cardio, weights, Yoga, Pilates)
    - □ Somewhat active (easy walking, light housework)
    - □ Moderately active (brisk walking, biking, hiking)
    - □ Not active (sit most of the day)

Comments: (Explain starred responses and note if the client has been referred to a Registered Dietitian, or other nutrition referral, or an outside agency)

_____

_____

_____

Participant Signature: _____ Date: _____

Staff Signature: _____ Date: _____