COLLEGE OF SOUTHERN IDAHO HEAD START/EARLY HEAD START
998 Washington St. N.
PO Box 1238
Twin Falls, Idaho 83303-1238
208-736-0741

EHS Expectant Mother Nutrition Screening

Date: ________________________

Name: _______________________ **DOB:** ________________ **Phone:** _____________________

Are you enrolled with the WIC Program? Yes/No

What was your weight before becoming pregnant? _________

1. How many pregnancies have you had including this one? ______
2. Have you experienced or are you experiencing nausea or vomiting with this pregnancy?___________________
3. Please describe any complications with this pregnancy or any complications you had with past pregnancies: (**Example:** Gestational diabetes, high blood pressure, etc.) ____
____
4. Please describe any existing medical conditions you may have. (**Example:** Depression, Thyroid disease , etc.):____
____
5. Please list any vitamins, minerals, herbs, or dietary supplements you currently take: ______________________
____
6. Please list any medications you are currently taking:____
7. Do you currently smoke, drink alcohol or take illegal drugs? Or did you before knowing you were pregnant? Please describe:____
8. Has your physician prescribed a special diet for you to follow during your pregnancy? Or, do you follow a special diet on your own? If so please describe:____
9. How do you plan to feed your baby?____

___________________________ ___________________________
Expectant Mother Signature **Date**

___________________________ ___________________________
Staff Signature **Date**

*Note to EHS HV: Send a copy of this form to EHS coordinator
* Note to RD: Return to Delia with copy of care plan.