PREGNANCY INVENTORY

Name _____ Age _____
Today's date _____ Height _____
Due date _____ Current weight_____
weeks gestation_____ Weight before pregnancy_____
Occupation/work hours_____

PREVIOUS PREGNANCIES

Have you ever been pregnant before? ☐ ☐
If yes: How many times prior to this one?_____
How long ago was your last pregnancy?_____
How much weight did you gain during your last pregnancy?_____
Did you experience any complications during your previous pregnancy?_____
_____

HEALTH HISTORY

Do you have any health problems?_____
If yes, are you under care for these problems?_____
Have you ever had a nutrition-related illness such as anemia?_____
Do you have any food allergies/intolerances?_____
Are you on any special diet (i.e., diabetic, vegetarian, weight loss)? If so, describe:_____
_____

NUTRITION HABITS

Do you eat at regular mealtimes?_____
How many meals do you eat each day?_____ How many snacks?_____
Do you eat breakfast?_____ How often?_____
Do you eat differently on weekends than on weekdays?
_____
How many times do you dine out weekly? _____Breakfast _____Lunch _____Dinner
What types of restaurants?_____
What do you drink with meals and in-between meals?_____
Do you think you have good eating habits?_____

PHYSICAL ACTIVITY

Do you exercise regularly or are you physically active throughout your typical day?
_____
What types of exercise do you prefer?_____
How many times per week?_____

MEDICATIONS/SUPPLEMENTS

List all medications you take:_____
List all supplements you take:_____
If taking pre-natal vitamin, what time of day?_____

PLEASE GIVE BEST ESTIMATE OF YOU EAT ON A TYPICAL DAY:

BREAKFAST
Time:
Place:

MIDMORNING SNACK

LUNCH
Time:
Place:

AFTERNOON SNACK

DINNER
Time:
Place:

EVENING SNACK

NOTES: