Weekly Nausea & Vomiting Assessment

Name: ___________________________ Date: _______ Gestational Age ______ weeks

TODAY’S Weight: ______ LAST WEEK’S Weight: ______ Weekly weight change: ______ Net Change: ______

Fill in the appropriate information for each day you are asked to evaluate your experience. Be as specific as possible on quantities. A family member may be helpful in filling out this form.

<table>
<thead>
<tr>
<th>Day of the week/Date</th>
<th>Rate intensity of nausea and food aversions (scale 0-5, 0 = none and 5 = extreme)</th>
<th>Retch or dry heaves (estimate number of times)</th>
<th>Vomit (amount in cups)</th>
<th>Water/liquids (number of glasses or ounces – small glass = 6 oz, large = 12 oz.)</th>
<th>Food Intake: (amount, i.e. 1/2 potato, 1 cup rice, etc.)</th>
<th>Activities: (work, read, childcare, sleep, rest, etc.)</th>
<th>Medication(s): Dose &amp; time (Cross out if you vomited less than 30 minutes after taking an oral medication.)</th>
<th>Questions for next OB visit or contact:</th>
<th>Notes: (triggers of nausea or vomiting, bowel function, IV hydration, mood, energy level, other problems)</th>
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