

HELP (HyperEmesis Level Prediction) SCORE

Name: _____ Date: _____ Gestational Age _____ (# of weeks preg.)

TODAY'S Weight: _____ LAST WEEK'S Weight: _____ % change: _____ Meds: _____

Mark ONE box in EACH ROW that most accurately describes your experience over the last: ____ days/weeks. **Previous Score:** ____

My nausea level most of the time: ____. (0 = none; 10 = worst possible)	0-2	3-4	5-6	7-8	9-10
I average ____ vomiting episodes daily.	0-2	3-5	6-8	9-12	13 or more
I retch/dry heave ____ episodes daily.	0-2	3-5	6-8	9-12	13 or more
I am urinating/voiding ____.	Same or more often, and light or normal color	Slightly less often, and normal color	At least every 8 hours or slightly dark yellow	Less than once every 8 hours or darker (concentrated)	Rarely and very little, dark color, blood, or foul smell
My average nausea/vomiting severity 1 hour after medications ____ or average if no meds. (0 = none; 10 = worst)	0-2	3-4	5-6	7-8	9-10
The number of hours I'm <u>unable</u> to work adequately at my job and/or at home has been ____. (average)	0-2 (hours are unchanged)	3-4 (can work part-time)	5-7 (barely able to work)	8-10 (can't care for family)	11-16 (can't care for myself)
I have been coping ____ with the nausea, vomiting and retching.	Normally or effectively	Slightly less than normal	Fairly good, it's tolerable, a little down	Struggling (e.g. moody, emotional)	Poorly (e.g. depressed, irritable)
I have been able to eat/drink ____ AND keep it down for at least 1 hour. Medium water bottle/ large cup = 2 cups/500mL.	Normally, 3 meals & 6+ cups fluid	Slightly less, 2 meals & some fluid	1 meal & few cups fluid; only fluid; only food	Very little, 0-1 meal & minimal fluids, daily IV	Nothing goes or stays down, daily IV/TPN
My anti-vomiting meds stay down/are tolerated:	Always	Nearly always or No Meds	Sometimes	Rarely	Never/ IV/SQ (subQ pump)
My symptoms compared to last week:	Better	About Same	Worse	Much Worse	Much worse!!!
	1 pt/answer	2 pts/answer	3 pts/answer	4 pts/answer	5 pts/answer
TOTAL each column = (# answers in column) x (# points for each answer)	_____	_____	_____	_____	_____

TOTAL for ALL columns: _____

Mild 0-17

Moderate 18-32

Severe 33-50

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Adapted from Rhodes INVR

Oncol Nurs Forum. 1999 Jun;26(5):889-94.

**NOTE: Scores of 30-35 require closer assessment to determine severity.



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This severity index is being evaluated for accuracy to offer clinicians a brief scoring tool to assess your symptoms. By answering the following questions and emailing (kimber@HelpHER.org) or faxing it to us, or completing the form online where it will be scored automatically, you are assisting us in our research. The online form will email you a copy of your results to share with your health professionals.



Online Link: www.surveymzmo.com/s3/2480713/6670497823a8 (or scan the QR code to the right with a smartphone)

1. How severe would you rate your level of nausea and vomiting symptoms:

- Mild Moderate Moderately-Severe Severe Extreme

2. How much weight have you lost since you became pregnant? _____ (pounds, kg, stone – **circle one**)

3. What was your starting weight? _____ (pounds, kg, stone – **circle one**)

4. What is your height? _____ (meters, cm, inches, feet/inches – **circle one**)

5. What medications are you taking and how much/often? (include **dose/frequency**)

(e.g. Zofran, Phenergan, Diclegis, Kytril, Compazine, Reglan, TPN, Zantac, Pepcid, Unisom)

6. What, if any, prenatal vitamins, supplements or IV vitamins are you receiving?

7. Do you want to add comments or additional information to help us understand how severe or mild your symptoms are?

8. Additional comments:

9. Your email address: _____ (Enter to join our research – it will NOT be shared.)



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