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.

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

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