Royal Cornwall Hospitals
NHS Trust

Hyperemesis Gravidarum and Severe Nausea and Vomiting in Pregnancy Clinical Guideline

V5.0

September 2026

1. Aim/Purpose of this Guideline

1.1. To inform midwives and obstetricians at Royal Cornwall Hospital of the diagnosis and management of women experiencing Hyperemesis Gravidarum (HG) and Nausea and Vomiting in Pregnancy (NVP).

NVP is defined as nausea and/or vomiting during pregnancy when the onset is prior to 16+0 weeks gestation with no other identifiable causes. NVP is experienced by up to 90% of women on a spectrum from very mild to very severe with associated complications. Onset of NVP is in the first trimester and if the onset is after 16+0 weeks gestation, other causes should be considered.

The Pregnancy-Unique Quantification of Emesis (PUQE) is a validated score to objectively assess severity of NVP and treatment response for mild to moderate NVP (New 2026).

HG is an extreme form of nausea and vomiting affecting up to 3.6% of women and is the most common indication for hospital admission among pregnant women. HG is defined as nausea and vomiting of which one is severe, beginning in early pregnancy (before 16+0 weeks of gestation), inability to maintain adequate oral intake, and significant impact on daily activities. Dehydration may be present but is not required for diagnosis (New 2026).

The Hyperemesis Level Prediction (HELP) score can be used to quantify HG symptoms into a score that can be used to monitor progression and response to treatment overtime. It is available as an online calculator (https://www.hyperemesis.org/tools/help-score/) and in app form (New 2026).

1.2. A validated scoring system (PUQE or HELP) should be documented at initial assessment and used to monitor response to treatment.1.2. Our role is also to manage expectations and be honest. Treatment is about managing rather than curing; none of the treatments are curative and some have unpleasant side effects. The overall aim will be to work as a team to manage the condition.

1.3. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns, and then ensure this is clearly documented in their notes to inform all health care professionals.

1.4. This version supersedes any previous versions of this document.

Data Protection Legislation

The Trust must comply with the UK GDPR, Data Protection Act 2018, and Data (Use and Access) Act 2025 by ensuring all personal data is processed lawfully, fairly, transparently, and for a defined purpose.

Before processing personal data, an appropriate Article 6 UK GDPR lawful basis must be identified and recorded. Where special category data is involved, a relevant Article 9 condition must also be documented.

All staff, contractors, students, volunteers, agency workers, and third parties working on behalf of the Trust are responsible for complying with data protection legislation.

Further guidance is available in the Trust's Information Use Framework and Information Governance policies. Advice can also be obtained from the Information Governance Team.

2. The Guidance

2.1. Referral Criteria

Women with mild NVP should be managed in the community with antiemetics. Day case or inpatientadmission should be used when community/primary care measures have failed (NICE 2015).

2.1.1. Day-Case Admission

- Unable to maintain adequate hydration or antiemetics orally at home.

2.1.2. Consider Inpatient Admission

- Continued nausea and vomiting and inability to keep down oral antiemetics after day case admission.
- Continued nausea and vomiting associated clinical dehydration with weight loss (greater than 5% of body weight), despite oral antiemetics.
- Confirmed or suspected comorbidity (such as urinary tract infection and inability to tolerate oral antibiotics).
- Comorbidities such as epilepsy, diabetes, HIV, hypoadrenalism or psychiatric disease where symptoms and inability to tolerate oral intake and medication could present further complications (New 2026).
- Haematemesis.
  - Significantly abnormal U +E`s (Na<120mmol/l).
  - Three previous attendances for day cases.

- The threshold for admission or seeking specialist advice should be lower for women with co-existing conditions.

2.2. Initial Assessment and Investigation

2.2.1. History (New 2026)

- Previous history of NVP/HG.
- Quantify severity using PUQE/HELP score (See Appendices) in severe cases / recurrent admissions.
- Ask about self-reported nutritional status or rapid weight loss.
- Ask about co-morbidities which may be complicated by lack of oral intake of essential medications such as epilepsy, diabetes, HIV, psychiatric conditions and hypoadrenalism.
- Relevant surgical history such as gastric bypass, band or sleeve.
- History to exclude other causes:
  - Abdominal pain.
  - Urinary symptoms.
  - Infection.
  - Drug history (prescription and/or recreational).
  - Chronic Helicobacter pylori infection.
- Consider using a validated questionnaire to assess the severity of symptoms, such as the Pregnancy-Unique Quantification of Emesis (PUQE) or Hyperemesis level prediction (HELP) scores.

2.2.2. Examination (New 2026)

- MEWS score.
- Signs of dehydration such as sunken eyes, dry lips and mouth, oliguria or anuria, tachycardia and hypotension.
- Neurological signs such as confusion, nystagmus or ataxia which could indicate Wernicke's encephalopathy.
- Abdominal examination.
- Weight on admission.

2.2.3. Investigations (New 2026)

- Urinalysis: Nitrites may indicate infection. The presence or absence of ketonuria in pregnancy is **not** an indicator of dehydration. **NB: if glycosuria as well as ketones consider diabetes.**
- MSU (if dipstick indicates signs of UTI).
- Urea and electrolytes – NVP and HG associated with hyponatremia, hypokalemia and low serum urea.
- Full blood count (FBC) - NVP and HG associated with raised haematocrit.
- Blood glucose monitoring - diagnose diabetes, exclude diabetic ketoacidosis in patients with diabetes.
- Ultrasound scan - assess if viable intrauterine pregnancy, multiple pregnancy or trophoblastic disease.
- In refractory cases or history of previous admissions, check:
  - TFTs: may be abnormal in up to two thirds of women with HG.
  - LFTs – abnormal in up to 40% of women with HG. Likely abnormalities are a rise in transaminases and mild elevation of billirubin and amylase.
  - Calcium and phosphate.
  - VBG - NVP and HG are associated with metabolic hypochloraemic alkalosis.

2.3. Differential Diagnosis

2.3.1. Findings which may suggest an alternative diagnosis include:

- Severe abdominal or epigastric pain (may require further investigation of serum amylase levels and an abdominal ultrasound and possibly oesophageal gastroduodenoscopy.
- Onset of symptoms after 16 weeks gestation.
- Fever.
- Headache or abnormal neurological examination.
- Goitre.

2.3.2. Conditions causing nausea and vomiting in pregnancy:

- Genito-urinary conditions – UTI, uraemia, pyelonephritis, ovarian torsion.
- Metabolic disorders and endocrine conditions – hypercalcaemia, thyrotoxicosis, diabetic ketoacidosis, Addison`s disease.
- Gastrointestinal conditions – gastritis, peptic ulcer, pancreatitis, bowel obstruction, hepatitis, appendicitis.
- ENT conditions e.g. labyrinthitis.
- Neurological disorders – vestibular disease, migraine.
- Other pregnancy-related conditions – acute fatty liver of pregnancy, pre-eclampsia (consider pre-eclampsia if the onset is of NVP is in second half of pregnancy).
- Drug induced vomiting – e.g. iron or opioids.
- Psychological disorders – e.g. eating disorders.

2.3.3. Complications of NVP and HG

2.3.3.1. Maternal

- Physical: Weight loss, dehydration, electrolyte disturbance, vitamin deficiencies, acidosis, Mallory-Weiss tear or oesophageal rupture, depression and social isolation, pressure damage to skin tissue, venous thromboembolism, re-feeding syndrome.
- Psychological: peri-natal depression, loss of identity, isolation.
- Social: unable to work and maintain household, financial hardship, relationship difficulties, concerns over care of other children.

2.3.3.2. Fetal

- Small for Gestational Age (SGA), low birth weight and prematurity. As a last resort, a mother may choose to terminate the pregnancy.

2.4. Management

- Care for NVP and HG should involve shared decision-making and early escalation of antiemetic therapy if symptoms persist.
- Refer patients to the Pregnancy Sickness Support website for peer support.

2.4.1. Fluid and Electrolyte Replacement

- Avoid dextrose containing fluids – carbohydrate rich fluids may precipitate Wernicke`s Encephalopathy in thiamine deficient states.
- 2000ml Hartman`s solution given over 4 hours.
- Additional fluid and electrolyte requirements should be adapted based on urinalysis and U+E`s.
- Thiamine must be administered before any dextrose-containing fluids to reduce the risk of Wernicke's encephalopathy.
- Caution when replacing sodium – risk of central pontine myelinolysis if replaced too rapidly.

2.4.2. Anti-emetic Therapy

- A slow-release combination of doxylamine and pyridoxine (vitamin B 6) called Xonvea®™ is the only licensed treatment of NVP in the UK.
- No other anti-emetics are currently licensed for use in pregnancy in the UK.
- Withhold non-essential medications associated with NVP e.g. oral iron.
- Continued regular prescription of anti-emetics is essential.
- A combination of medications may be required.
- Prescribe at times which give maximum effect at mealtimes.
- Consider which anti-emetics have had an adverse effect or been most effective for the woman historically.

2.4.2.1. First line Anti-emetic therapy

Cyclizine 50 mg PO, IM or IV 8 hourly. Note that women taking cyclizine may require laxatives if constipation develops.

Or

Prochlorperazine 5–10 mg 6–8 hourly PO (or 3 mg buccal); 12.5 mg 8 hourly IM.

Or

Promethazine Hydrochloride 12.5–25 mg 4–8 hourly PO, IM or IV (note the significant sedative effect of promethazine).

2.4.2.2. Second line Anti-emetic

Doxylamine and Pyridoxine (vitamin B6) 20/20mg PO at night, increase to additional 10/10 mg in morning and 10/10mg at lunchtime if required.

Or

Metoclopramide 5–10 mg 8 hourly PO, IV/IM/SC. Note risk of oculogyric crisis in young women – MHRA advises short term use only. Emergency treatment of oculogyric crisis: IV Procyclidine 10mg STAT. Not to be given with prochlorperazine.

Or

Domperidone 10 mg 8 hourly PO;

Or

Ondansetron 4 mg 8 hourly or 8 mg 12 hourly PO; 8 mg over 15 minutes 12 hourly IV; Counsel about a small increase in risk of cleft lip/palate if taken in the first trimester. Note that women taking ondansetron may require laxatives if constipation develops.

2.4.2.3. Third line Anti-emetic

Hydrocortisone 100 mg twice daily IV and once clinical improvement occurs, convert to prednisolone 40–50 mg daily PO, with the dose gradually tapered (by 5-10 mg per week) until the lowest maintenance dose that controls the symptoms is reached.

- Corticosteroids should be reserved for cases where standard therapies have failed; when initiated they should be prescribed in addition to previously started effective antiemetics. Women taking corticosteroids should have their blood pressure monitored and a screen for diabetes mellitus.

Or

Granisetron patch: For those unable to tolerate oral medication, use of granisetron patches may be very helpful. Prescribe 1 patch (lasts a week) and review 1 week later.

N.B. Omeprazole: Discuss symptoms of acid reflux and prescribe omeprazole if needed.

2.4.3. Nutrition

- Encourage oral fluids when they can be tolerated.
- Record fluid balance.
- Encourage frequent snacks of “safe foods” when able to eat.
- Use MUST (Nutrition Assessment) tool in severe cases.
- Assistance to eat when required.
- Consider referral to Dietician in severe cases.

2.4.4. Vitamins

- If unable to tolerate oral diet and fluid, Pabrinex or IV Thiamine should be administered according to medication information leaflet given and electronic prescribing.
- For those tolerating oral diet and fluid, Oral Thiamine 100mg x 3 daily should be routinely given to all women admitted to hospital with severe prolonged vomiting or 2+ attendances for day case treatment.

2.4.5. Thromboprophylaxis

A VTE assessment must be completed on admission and LMWH given to all clinically dehydrated patients on bedrest.

2.5. Midwifery Care

- Accurate fluid balance for inpatients.
- MEWS 4 hourly.
- Weigh woman on each admission or weekly if she remains an inpatient.
- Women report that sensory stimulation is a trigger for vomiting therefore nurse in a side room if possible.
- Staff should not smell of smoke or use perfume.
- Women should have easy access to a supply of clean vomit bowls.
- Used vomit bowls should be cleared away promptly.
- Ensure timely medication administration to enable stable blood levels of anti-emetics.
- Assist women with personal hygiene.
- Staff should ask before discussing food with woman in case it triggers further vomiting.

- Do not suggest use of ginger, sea bands etc. as are ineffective for severe NVP and HG and inaccurate information may cause mistrust in healthcare professionals.
- Give written information/ support groups (Pregnancy Sickness Support).
- Advise women to seek early treatment for constipation caused by dehydration. Malnutrition, immobility, or medication (Ondansetron/Cyclizine).
- Emotional and psychological support. Ensure that the woman feels that she is listened to and her symptoms believed. Signpost woman to pregnancy sickness support charity. In extreme cases refer woman to the Perinatal Mental Health Team if appropriate.
- Regular bloods (U+Es) as per obstetric plan, to assess the need for further supplements such as potassium (RCOG).

2.6. **Discharge**

- Give TTO anti-emetics orally or PR even if the woman is well on discharge. Ensure that the woman is aware that Thiamine is needed as a vitamin supplement if she continues to vomit. LMWH should be prescribed as a TTO.
- Give dietary advice:
  - Eat dry biscuits, bread, or cereal before getting up in the morning; get out of bed slowly and avoid sudden movements.
  - Drink fluid between meals rather than with meals to reduce volume of intake.
  - Avoid large, greasy, or spicy meals.
  - Keep rooms well-ventilated and odour free.
- Women with severe hyperemesis or nausea and vomiting in pregnancy who have continued symptoms into the late second or third trimester should be offered serial growth scans to monitor fetal growth (RCOG).
- If the woman`s symptoms were severe enough to require medication, inform her Community Midwife of discharge and arrange follow up after 24 hours to check for ketones in the urine, signs of dehydration (e.g. infrequent urination, dry mucous membranes, light-headedness) and assess response to medication.
- A maxims discharge letter must be completed by a doctor that includes the medications provided at the point of discharge.
- An electronic discharge must be completed by the midwife.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	• The audit will take into account record keeping by midwives and medical staff. • The audit will be registered with RCHT's Audit Department.
Lead	Antenatal Ward Manager
Tool	• Was the correct referral pathway followed? • On admission was the first dose of antiemetic given IM/IV? • Was an adequate fluid balance chart kept on all patients? • With severe prolonged vomiting was the patient prescribed Thiamine 50mgs TDS? • Did the patient have 4 hourly MEWS? • Was a urinalysis taken for each specimen of urine?
Frequency	1% or 10 sets of notes, whichever is greatest, of all health records of patients admitted with hyperemesis gravidarum.
Reporting arrangements	• A formal report of the results will be received annually at the Obstetric Patient Safety Forum and at the Clinical Audit Forum, as per the audit plan. • During the process if the audit compliance is <75% or other deficiencies identified, this will be highlighted at the next Obstetric Maternity Patient Safety Forum and Clinical Audit Forum and an action plan agreed.
Acting on recommendations and Lead(s)	• Any deficiencies identified will be discussed at the Obstetric Patient Safety Forum and Clinical Audit Forum and an action plan developed. • Action leads will be identified and a time frame for action to be completed. • The action plan will be monitored by the Audit Midwife until all actions are complete.
Change in practice and lessons to be shared	• Required changes to practice will be identified and actioned within a time frame agreed on the action plan. • A lead member of the forum will be identified to take each change forward. • The results of the audits will be distributed to all staff through the Patient Safety Newsletter.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity and Inclusion Policy or the Equality and Diversity website.

4.2. Quality and Equality Impact Assessment (QEIA)

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged. The Quality and Equality Impact Assessment (QEIA) Form is available via the link in Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Hyperemesis Gravidarum and Severe Nausea and Vomiting Clinical Guideline V5.0
This document replaces (exact title of previous version):	Hyperemesis Gravidarum and Severe Nausea and Vomiting Clinical Guideline V4.0
Date Issued/Approved:	September 2026
Date Valid From:	September 2026
Date Valid To:	September 2029
Directorate/Department responsible (author/owner):	Annie Thomas, Antenatal Ward Manager.
Contact details:	01872 252149
Brief summary of contents:	To inform midwives and obstetricians of care pathways and management for women suffering from Moderate - Severe Nausea and Vomiting in pregnancy (NVP) and Hyperemesis Gravidarum (HG).
Suggested Keywords:	Hyperemesis, Gravidarum, nausea, sickness, pregnancy, vomiting, severe.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	None required
Related Documents:	• Dean C., Shortman A (2014) Hyperemesis Gravidarum: The Definitive Guide.

Information Category	Detailed Information
	• Nelson-Piercy C et al (2011) Management of nausea and vomiting in pregnancy: British Medical Journal Vol 342 pp1-8. • NICE (2017) https://cks.nice.org.uk/nauseavomiting-inpregnancy#!topicsummary • The Management of nausea and Vomiting of Pregnancy and Hyperemesis Gravidarum • RCOG Green-top Guideline No. 60 (2016).
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
July 2015.	V1.0.	Initial Issue.	Karen Stoyles, Antenatal Ward and Day Assessment Unit Manager
June 2018.	V2.0.	Amendments: 2.2 Re-formatting complications with additions. 2.6 Frequency of anti-emetics. 2.6.4 Ondansetron 2nd line therapy Additions. 2.3 Additions to management. 2.6.4 Metoclopramide. 2.6.7 Vitamins. 2.7 Daily blood samples. 2.8 Serial Growth Scans.	Katie Letcher, Antenatal Midwife

Date	Version Number	Summary of Changes	Changes Made by
February 2021	V3.0	Full version update Amendments: • Addition of Day Case Management flow chart and clear prescribing guidance. • Update to information re complications of HG and reasons for admission. • Metoclopramide to be reserved for short-term use. • Addition of Appendix 3 – discharge letter for CMW/GP for ongoing care in community.	Emma Shephard, ST3 Obstetrics and Gynaecology
March 2024	V4.0	Full Update – no updates required.	Laura Rowe, Antenatal Ward Manager
September 2026	V5.0	• Aligning current local guideline for Hyperemisis Gravidarum with national guidance. • Implementing/launching the PUHQ scores. • Introduction of Xonvea.	Rob Harper, Obstetric Consultant

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus six years.

This document is only valid on the day of printing.

Controlled Document.

- This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

E11 QEIA Policy

For guidance, please see the QEIA Essentials – Quick Reference Guide or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net

Appendix 3. Discharge letter for use with women with NVP/HG

Wheal Rose Ward / Day Assessment Unit
Royal Cornwall Hospital
Truro
TR1 3LJ

Dear Dr.

This is to inform you that one of your patients has attended with nausea and vomiting in pregnancy / hyperemesis gravidarum and will require an ongoing repeat prescription.

Gestation: __/40

Day case admission / Inpatient admission (circle) **Attendance number:** _____

Discharge medication: (circle)

Anti-emetics	**Other**
Doxylamine with pyridoxine (Xonvea®) 20/20mg PO OD	Lactulose
Prochlorperazine 5mg PO TDS	Laxido
Cyclizine 50mg PO TDS	Omeprazole 20mg BD
Ondansetron 4mg PO TDS	Thiamine 50mg OD TDS
Metoclopramide 10mg PO TDS	
Ondansetron 16mg PR OD	
Steroid reducing dose regime (see separate TTO)	

General advice:

- Combinations of anti-emetic medication are likely to be required to manage symptoms – please add in further medication as above if required.
- Dietary advice:
  - Eat dry biscuits, bread, or cereal before getting up in the morning; get out of bed slowly and avoid sudden movements.
  - Drink fluid between meals rather than with meals to reduce volume of intake.
  - Avoid large, greasy, or spicy meals.
  - Keep rooms well-ventilated and odour free.

For further support, see Pregnancy Sickness Support.

(http://www.pregnancysicknesssupport.org.uk) - provides a helpline, forum, 1:1 support and lots of useful information.

Many thanks for your ongoing care.

For any questions or concerns please contact us:	
Wheal Rose Ward	01872 252149
Maternity Triage	01872 255980
On-call Obstetric SpR	Via switch

Signature:

Name: **Date:**

Appendix 4. Pregnancy-Unique Quantification of Emesis (PUQE)

RCOGHyperemesis

Total score is sum of replies to each of the three questions. PUQE-24 score: Mild ≤ 6; Moderate = 7–12; Severe = 13–15.

Motherisk PUQE-24 scoring system					
In the last 24 hours, for how long have you felt nauseated or sick to your stomach?	Not at all (1)	1 hour or less (2)	2–3 hours (3)	4–6 hours (4)	More than 6 hours (5)
In the last 24 hours have you vomited or thrown up?	7 or more times (5)	5–6 times (4)	3–4 times (3)	1–2 times (2)	I did not throw up (1)
In the last 24 hours how many times have you had retching or dry heaves without bringing anything up?	No time (1)	1–2 times (2)	3–4 times (3)	5–6 times (4)	7 or more times (5)

PUQE-24 score: Mild ≤ 6; Moderate = 7–12; Severe = 13–15.

How many hours have you slept out of 24 hours? _____ Why? _____

On a scale of 0 to 10, how would you rate your wellbeing? _____

0 (worst possible) → 10 (the best you felt before pregnancy)

Can you tell me what causes you to feel that way? _____

Appendix 5. Hyperemesis Level Prediction (HELP) score

HyperEmesis Level Prediction (HELP Score) Identifies Patients

My nausea level most of the time:	0	1 (mild)	2	3 (moderate)	4	5 (severe)
I average ..... vomiting episodes/day:	0	1–2	3–5	6–8	9–12	13 or more
I retch/dry heave ..... episodes daily:	0	1–2	3–5	6–8	9–12	13 or more
I am urinating/voiding:	Same	More often due to IV fluids; or light color	Slightly less often, and normal color	Once every 8 hours; or slightly dark yellow	Less than every 8 hours or darker	Rarely; dark or bloody; or foul smell
Nausea/vomiting severity 1 hour *after* meds **or** after food/drink if no meds:	0 or no meds	1 (mild)	2	3 (moderate)	4	5 (severe)
Average number of hours I'm *unable* to work adequately at my job and/or at home due to being sick has been:	0	1–2 (hours are slightly less)	3–4 (can work part time)	5–7 (can only do a little work)	8–10 (can't care for family)	11+ (can't care for myself)
I have been coping with the nausea, vomiting and retching:	Normal	Tired but mood is okay	Slightly less than normal	It's tolerable but difficult	Struggling: moody, emotional	Poorly: irritable, depressed
Total amount I have been able to eat/drink **and** keep it down: Medium water bottle/large cup = 2 cups/500 mL	Same; no weight loss	Total of about 3 meals and 6+ cups fluid	Total of about 2 meals and some fluid	1 meal and few cups fluid; or only fluid or only food	Very little, < 1 meal/ minimal fluids; or frequent IV	Nothing goes or stays down, or daily **IV/TPN/NG**
My anti-nausea/vomiting meds stay down or are tolerated:	No meds	Always	Nearly always	Sometimes	Rarely	Never/**IV/SQ** (SubQ pump)
My symptoms compared to last week:	Great	Better	About same	Worse	Much worse	So much worse!!!
Weight loss over last 7 days:	0%	1%	2%	3%	4%	5%
Number of Rx's for nausea/vomiting*:	0	1	2	3	4	5+
	0 pts	**1 pt/answer**	**2 pts/answer**	**3 pts/answer**	**4 pts/answer**	**5 pts/answer**
Total each column = (No. of answers in column) × (No. of points for each answer)	0	.....	.....	.....	.....	.....
Total for all columns: _____		None/mild ≤ 19	Moderate 20–32		Severe 33–60	

$$\text{Weight loss (\%)} = \left(\frac{\text{amount lost}}{\text{pre-pregnancy weight}}\right) \times 100$$

(Weight loss calculation optional for home use)

* Number of Rx's = number of Rx medications for HG (not doses)

IV = Intravenous
TPN = Total parenteral nutrition (IV nutrition)
NG = Nasogastric tube feeding
SQ/SubQ = Subcutaneous
Rx = Prescription medication