

Postpartum Woman's Health and Diet Questions - A (Initial Certification)

Your name _____ Today's Date ____/____/____ Your date of birth ____/____/____

Question 1 a-c is optional. Your answer will be used for reporting purposes. If you do not answer, a selection will be made for you by the staff. This does not affect you receiving WIC benefits.

1. a. Are you Hispanic or Latino? Yes No
- b. Are you Arabic? Yes No
- c. Check (✓) all races that apply to you:

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Native Hawaiian or other Pacific Islander
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Black or African American	

race

Please answer the following questions. These questions are asked to see if you may be eligible for the WIC Program. Please check (✓) your answer or fill in the blank. All answers are confidential.

2. What was your weight just before you became pregnant this time? _____
3. How much weight did you gain during the pregnancy? _____ (pounds) (CDC)
4. When did your pregnancy end? _____ (CDC)
 Month Day Year
5. How many times have you been pregnant, **including this pregnancy**? _____
 (Count any abortions, miscarriages or stillbirths)
6. Where did you go for most of your medical care during your most recent pregnancy?

<input type="checkbox"/> 1. Hospital clinic	<input type="checkbox"/> 4. I had no prenatal care
<input type="checkbox"/> 2. Health department clinic	<input type="checkbox"/> 5. Other _____
<input type="checkbox"/> 3. Doctor's office or HMO	
7. For your most recent pregnancy, how did you pay for medical care?

<input type="checkbox"/> 1. Private health insurance	<input type="checkbox"/> 4. Self or family
<input type="checkbox"/> 2. HMO	<input type="checkbox"/> 5. I had no way to pay
<input type="checkbox"/> 3. Medicaid/Healthy Kids	<input type="checkbox"/> 6. Other _____
8. When did your prenatal care begin? _____
 (For example: 2 months; 4 months pregnant) (months pregnant)
9. Are you currently: 1. Not married 2. Married
10. How many grades of school have you completed? _____
 grades completed
11. Are you taking any medicines (prescription or non-prescription) or street drugs? No Yes
 357+, 372
 - a. If yes, for what problem _____
 - b. If yes, what medications/drugs _____
 - _____
 - c. If yes, list side effects, if any _____

pregnand wt.

gravidity

prenatal place

prenatal source

prenatal care

marital status

mother's education

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12. Have you taken any vitamins or minerals in the past month? No Yes (CDC)
If yes, what are you taking? _____
13. In the month before you got pregnant with this baby, how many times a week did you take a multivitamin (a pill that contains many different vitamins and minerals)? _____ (CDC)
14. Are you consuming folic acid from fortified foods and/or taking a folic acid supplement daily? No Yes 426
(For CPA, less than 400 mcg folic acid from fortified foods or supplements daily = risk)
15. Do you have any concerns about your breast changes or breast health? No Yes
16. During your most recent pregnancy, were you told by a doctor that you had gestational diabetes?
 No Yes 303 (CDC)
17. During your most recent pregnancy, did you have high blood pressure? No Yes 345+ (CDC)
18. Please check (✓) which is true about any previous **deliveries before this pregnancy**:
 I have never been pregnant before
 History of Gestational Diabetes
 Infant weighed 9 pounds or more 337
19. Do you have dental problems that make it difficult to eat? No Yes 381

ALCOHOL USE

20. Please check (✓) what is true about your drinking habits.
 I do not drink.
 I drink less than two alcoholic beverages per day.
 I drink two or more drinks per day. 372
 I drank 5 or more drinks in one day in the last month. 372
 I drank 5 or more drinks on 5 or more days in the last month. 372
21. During the last **three months of your pregnancy**, how many days each week or each month did you drink any alcoholic drinks on the average? (CDC)
Number of days each week _____ **OR** Number of days each month _____
22. During the last **three months of your pregnancy**, on the days when you drank, about how many alcoholic drinks did you have in an average week? (CDC)
A drink is: 1 shot of liquor, 1 can or bottle of wine cooler,
1 can or bottle of beer, 1 glass of wine, or 1 cocktail

Average number of drinks _____ **OR** No drinks _____
372
23. **Since your pregnancy ended**, how many days each week or each month do you drink any alcoholic drinks on the average? (CDC)
Number of days each week _____ **OR** Number of days each month _____
372
24. **Since your pregnancy ended**, on the days when you drink alcohol, about how many drinks do you drink on the average? (CDC)
Average number of drinks _____ **OR** No drinks _____
372 (≥2)

	Days last trimester
	Drinks last trimester
	Alcohol now days/week
	Alcohol now drinks/day

TOBACCO USE

25. Do you smoke cigarettes, pipes or cigars? No Yes
371 (B only tobacco)

26. If yes to #25, how many cigarettes or packs of cigarettes, pipes or cigars do you smoke on an average day **now**?
Number per day _____ (cigarettes packs -- circle one) (CDC)

Cigarettes now

27. During the last **three months of your pregnancy**, how many cigarettes, pipes or cigars did you smoke on an average day? (20 cigarettes = 1 pack) (CDC)
Number per day _____ **OR** I did not smoke _____

Cigarettes last trimester

28. Did you change your smoking habits during your most recent pregnancy? (CDC)
 I did not smoke (8) No change, tried to cut down but didn't (3)
 Stopped completely (2) No change, smoking the same (7)
 Cut down (1) I don't know (9)
 Started smoking (4)

Cigarettes change

29. Does anyone else living in your household smoke inside the home? No Yes (CDC)

30. Would you like birth control or family planning information? No Yes

YOUR HEALTH:

What are your snacks and meals like:
(When, where, with who?)

What foods do you think you don't get enough of:

How do you feel about your weight:

What activities do you like to do:

How many meals do you eat most days? _____ How many snacks do you eat most days? _____

How many times do you drink milk in a day? _____

Is your appetite usually: Good _____ Fair _____ Poor _____

Are you on a special diet (prescribed by a doctor)? _____ 403+

How many times in a week do you eat Fast Food? _____

Do you eat or drink any of the following everyday or most days? (Check all that apply)

1. ___ Milk What kind _____
2. ___ Pop or other sweetened beverages
3. ___ Sweets or salty snacks
4. ___ Whole grains
5. ___ Fruits and vegetables?

Do you eat or drink any of the following? (Check all that apply) 405

6. ___ Unpasteurized (raw) juice or milk
7. ___ Soft cheese (like feta, brie, camembert, blue or Mexican style cheese such as queso blanco, queso fresco or Panela unless labeled as made with pasteurized milk)
8. ___ Raw or undercooked (rare) meat, fish, poultry or eggs
9. ___ Raw sprouts or raw or undercooked tofu
10. ___ Refrigerated pate or meat spreads or refrigerated smoked seafood?
11. ___ Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot

Do you? (Check all that apply)

12. ___ Eat a strict vegetarian diet 402+ or 403+
13. ___ Eat a low calorie/weight loss diet 403+
14. ___ Eat a low-carbohydrate, high protein diet (like Atkins, etc.) 403+
15. ___ Eat little food because of stomach surgery to lose weight 403+
16. ___ Regularly eat non-food items (ashes, carpet fibers, cigarettes or cigarette butts, clay, dust, foam rubber, paint chips, soil, laundry starch or corn starch) 421+
17. ___ Use herbal supplement remedies or teas (what kind _____)

423

Please answer the following if you are able: check (✓) what is true about your **most recent pregnancy or delivery.**

- | | |
|---|---|
| <input type="checkbox"/> Miscarriage 321 | <input type="checkbox"/> Less than 16 months between end of last pregnancy and beginning of this one 332 |
| <input type="checkbox"/> Infant died within first 28 days of life 321 | <input type="checkbox"/> Less than 20 years of age when I became pregnant and had 3 or more previous pregnancies lasting 5 months or more 333 |
| <input type="checkbox"/> Less than 18 years of age when I became pregnant 331 | |

Thank you for completing this form. Please let the staff know you are finished.

WIC STAFF USE ONLY

Biochemical Risk		Non-Smoking		Any Smoking Up to 19 cigarettes/day		Any Smoking 20 to 39 cigarettes/day		Smoking 40 or more cigarettes/day	
				Hct.%	Hgb. gm	Hct.%	Hgb. gm	Hct.%	Hgb. gm
Code	Status								
201	BN Postpartum 15 years	<36.0	<12.0	<37.0	<12.3	<38.0	<12.5	<38.0	<12.7
	BN Postpartum <15 years	<36.0	<11.8	<37.0	<12.1	<38.0	<12.3	<38.0	<12.5

WIC Anthropometric Risk			BMI Table for Determining Weight Classification for Non-Pregnant Women				
<u>High Maternal Weight Gain*</u>	112	<u>Category C and D OVERWEIGHT</u>	Height	A	B	C	D
133	Category A > 40#	Non-breastfeeding and breastfeeding women <6 months postpartum, pre-Pregnancy BMI ≥25.	inches	BMI <18.5	BMI 18.5-24.9	BMI 25.0-29.9	BMI >30.0
	Category B > 35#		58	<89	89-118	119-142	>142
	Category C > 25#		59	<92	92-123	124-147	>147
	Category D > 15#	102 <u>Category A UNDERWEIGHT</u>	60	<95	95-127	128-152	>152
		Non-breastfeeding and breastfeeding Women < 6 months postpartum, pre-pregnancy or current BMI < 18.5.	61	<98	98-131	132-157	>157
			62	<101	101-135	136-163	>163
			63	<105	105-140	141-168	>168
			64	<108	108-144	145-173	>173
			65	<111	111-149	150-179	>179
			66	<115	115-154	155-185	>185
			67	<118	118-158	159-190	>190
			68	<122	122-163	164-196	>196
			69	<125	125-168	169-202	>202
			70	<129	129-173	174-208	>208
			71	<133	133-178	179-214	>214
			72	<137	137-183	184-220	>220
				*Based on Body Mass Index Estimates			

Referral Codes:

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> 01 EPSDT <input type="checkbox"/> 02 Family Planning <input type="checkbox"/> 03 Infant Support Services <input type="checkbox"/> 04 Maternal Support Services <input type="checkbox"/> 05 Hearing Screening <input type="checkbox"/> 06 Vision Screening <input type="checkbox"/> 07 Public Health Nursing <input type="checkbox"/> 08 Children's Special Health Care Services <input type="checkbox"/> 09 Food Stamps/Cash Out <input type="checkbox"/> 10 Family Independence Agency <input type="checkbox"/> 11 Medicaid <input type="checkbox"/> 12 Preventive/Protective Services <input type="checkbox"/> 13 MSU Extension <input type="checkbox"/> 14 Intermediate School District <input type="checkbox"/> 15 Substance Abuse Counseling/Treatment <input type="checkbox"/> 16 Dental <input type="checkbox"/> 17 Private Physician <input type="checkbox"/> 18 Registered Dietitian-WIC <input type="checkbox"/> 19 Registered Dietitian-Non-WIC <input type="checkbox"/> 20 STD Clinic <input type="checkbox"/> 21 Well Child Clinic <input type="checkbox"/> 22 Com. Mental Health & Mental Health Serv. <input type="checkbox"/> 23 Healthy Kids (MICH-CARE) <input type="checkbox"/> 24 Prenatal clinic <input type="checkbox"/> 25 Head Start <input type="checkbox"/> 26 CSFP/Focus: HOPE <input type="checkbox"/> 27 Emergency Food Pantry/ Programs & TEFAP | <ul style="list-style-type: none"> <input type="checkbox"/> 28 Non-Food Emergency Services <input type="checkbox"/> 29 Job Training Employment <input type="checkbox"/> 30 Migrant Services <input type="checkbox"/> 31 Parenting Classes <input type="checkbox"/> 32 Lactation Specialist <input type="checkbox"/> 33 Breastfeeding Peer Support-LLL <input type="checkbox"/> 34 Early On <input type="checkbox"/> 35 Legal Aid <input type="checkbox"/> 36 Environmental Health <input type="checkbox"/> 37 Lead Screening <input type="checkbox"/> 38 MI Child <input type="checkbox"/> 39 Prenatal Enrollment/Coordination Program <input type="checkbox"/> 40 Immunization Assessment w/ Card <input type="checkbox"/> 41 Immunization Assessment-No Card <input type="checkbox"/> 42 Immunization Card-No Assessment <input type="checkbox"/> 43 No Immunization Card-No Assessment <input type="checkbox"/> 44 Vaccinated in WIC <input type="checkbox"/> 45 Immunization Referral-Local Imm. Clinic <input type="checkbox"/> 46 Immunization Referral-Doctor <input type="checkbox"/> 47 No Immunization Needed <input type="checkbox"/> 50 New Voter Registration <input type="checkbox"/> 51 Voter Changed Address <input type="checkbox"/> 52 Voter Registration Declined <input type="checkbox"/> 53 Voter Mailed Form <input type="checkbox"/> 59 Social Worker <input type="checkbox"/> 60 Healthy Start | <ul style="list-style-type: none"> <input type="checkbox"/> 61 Summer Feeding Program <input type="checkbox"/> 62 Child Support Services <input type="checkbox"/> 63 Smoking Cessation <input type="checkbox"/> 64 Project FRESH <input type="checkbox"/> 65 Women's Shelter/Resource <input type="checkbox"/> 66 Strong Families/Safe Children <input type="checkbox"/> 67 Maternity Outpatient Med. Serv. Prog. (MOMS) <input type="checkbox"/> 95 <input type="checkbox"/> 96 <input type="checkbox"/> 97 <input type="checkbox"/> 98 <input type="checkbox"/> 99 |
|--|--|--|

CPA Notes Nutrition Education Plan:

CPA Signature _____ Date _____