PREGNANT WOMAN’S HEALTH AND DIET QUESTIONS
Michigan Department of Health and Human Services

Today's date

Your name

How many grades of school have you completed? Are you currently?
☐ Married  ☐ Unmarried

The following question is optional. Your answer will be used for group reporting purposes. If you do not answer, the staff will make a selection for you. This does not affect you receiving WIC benefits.

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<th>Are you Hispanic or Latino?</th>
<th>Are you Arabic?</th>
<th>Check all races that apply to you:</th>
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<tbody>
<tr>
<td>☐ Yes  ☐ No</td>
<td>☐ Yes  ☐ No</td>
<td>☐ American Indian or Alaska Native</td>
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<td>☐ Native Hawaiian or Other Pacific Islander</td>
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Pregnancy Information

What was the date of your last menstrual period?  When is your baby due?
Month/Day/Year__________________  Month/Day/Year__________________

What was your weight just before you became pregnant with this baby?  (CDC)
_____ pounds

1. How many times have you been pregnant?
   (Count any abortions, miscarriages or stillbirths)  How many live babies have you had?
   How many times have you been pregnant for 20 weeks or more before this pregnancy?  (CDC)
   ☐ None
   ☐ Number of pregnancies  ________
   ☐ Unknown
   If you have been pregnant before, when did your last pregnancy end?  Month/Day/Year__________________
   (Date of last delivery, abortion, miscarriage or stillbirth)

2. How many months were you pregnant when you had your first visit for prenatal care from a doctor or a certified nurse midwife for this current/most recent pregnancy?  (CDC)
   ☐ First month
   ☐ Second month
   ☐ Third month
   ☐ Fourth month
   ☐ Fifth month
   ☐ Sixth month
   ☐ Seventh month
   ☐ Eighth or Ninth month
   ☐ Unknown
   ☐ No Medical Care

3. For this pregnancy, check all that apply. I have:
   ☐ Some weight loss during pregnancy  ☐ Fetal Growth Restriction (Intrauterine Growth Retardation)
   ☐ Severe nausea and vomiting  ☐ High blood pressure (or preeclampsia) because of this pregnancy
   ☐ Gestational Diabetes (high blood sugar)  ☐ None apply
   ☐ Twins or more expected

4. How many times have you seen your health provider for this pregnancy?  ________

   Where do you receive your regular prenatal care?

5. Have you been offered a blood test for HIV?  ☐ Yes  ☐ No
6. For any previous pregnancies, please check all that occurred:

- History of Gestational Diabetes (GDM or high blood sugar)
- History of Preeclampsia (diagnosed pregnancy high blood pressure/hypertension)
- Infant born alive, but died before 1 month
- Premature delivery (36 weeks or less)
- Infant weighed 5 pounds, 8 ounces or less at birth
- Infant died after 5 months of pregnancy
- Miscarriage
- Infant born with congenital or other birth defects
- Infant weighed 9 pounds or more at birth
- None apply

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### Medical Information

1. **Medical conditions/recent illnesses:** WIC staff will give you a list of medical conditions to review. We will later ask which you may have. If you have a medical condition and are unsure if it is listed, please discuss this with the WIC nutritionist.

2. Since you became pregnant, have you taken any medicines (prescription or non-prescription) or street drugs?
   - Yes □ No □
     If yes, what kind?
     Any side effects?
     - Yes □ No □
       If yes, what kind?

3. Do you have any oral/dental problems that make it difficult to eat?
   - Yes □ No □
     If yes, what?
     Have you seen a dentist or had oral care during this pregnancy?
     - Yes □ No □

4. In the month before this pregnancy, how many times did you take a multivitamin that contained several different vitamins and minerals? (CDC)
   - Less than once per week
   - Number of times per week (1-7)
   - 8 or more times per week
   - Unknown

5. Have you taken any vitamins or minerals in the past month? (CDC)
   - Yes □ No □
   - Unknown

6. In the 3 months before you were pregnant, how many cigarettes did you smoke on an average day? (20 cigarettes = 1 pack) (CDC)
   - Did not smoke
   - Number of cigarettes per day (1 – 96)
   - 97 or more cigarettes per day
   - Smoked, but quantity unknown
   - Unknown or refused

7. How many cigarettes do you smoke on an average day now?
   - Do not smoke
   - Number of cigarettes per day (1 – 96)
   - 97 or more cigarettes per day
   - Smoked, but quantity unknown
   - Unknown or refused

8. Does anyone else living inside your household smoke inside the home? (CDC)
   - Yes, someone else smokes inside the home
   - No, no one else smokes inside the home
   - Unknown

9. In the 3 months before you got pregnant, how many alcoholic drinks (beer, wine, liquor, wine coolers) did you have in an average week? (CDC)
   - Did not drink
   - Number of drinks per week (1 – 20)
   - 21 or more drinks per week
   - Drank, but quantity unknown
   - Unknown or refused
10. Have you had any alcoholic drinks during this pregnancy?
   - [ ] Yes
   - [ ] No

**Nutrition History**

1. Have you ever breastfed any children?  - [ ] Yes  - [ ] No
2. Are you currently breastfeeding another child?  - [ ] Yes  - [ ] No
3. Are you currently breastfeeding two children from the same pregnancy?  - [ ] Yes  - [ ] No
4. How many **meals** do you eat most days?  - [ ] 0  - [ ] 1  - [ ] 2  - [ ] 3  - [ ] 4  - [ ] 5 or more
5. How many **snacks** do you eat most days?  - [ ] 0  - [ ] 1  - [ ] 2  - [ ] 3  - [ ] 4  - [ ] 5 or more
6. How many times do you **drink milk or eat yogurt or cheese** in a day?  - [ ] 0  - [ ] 1  - [ ] 2  - [ ] 3  - [ ] 4  - [ ] 5 or more
7. Is your **appetite** usually:  - [ ] Good  - [ ] Fair  - [ ] Poor
   - [ ] Yes
   - [ ] No
   - If yes, what kind?
8. Are you on a **special diet** (prescribed by your doctor)?
   - [ ] Yes
   - [ ] No
   - If yes, what kind?
9. How many times a week do you eat **Fast Food**?  - [ ] 0  - [ ] 1  - [ ] 2  - [ ] 3  - [ ] 4  - [ ] 5 or more
10. Do you have any **food allergies**?
    - [ ] Yes
    - [ ] No
    - If yes, what kind?
11. Do you eat or drink any of the following every day or most days? (Check all that apply)
    - [ ] Milk
    - [ ] Pop or other sweetened beverages
    - [ ] Sweets or salty snacks
    - [ ] Whole grains
    - [ ] Fruits and vegetables
12. Do you eat or drink any of the following? (Check all that apply)
    - [ ] Raw (unpasteurized) juice or milk
    - [ ] Soft cheese (feta, Camembert, Brie, queso blanco, queso fresco, Panela)
    - [ ] Raw or undercooked (rare) meat, fish, poultry or eggs
    - [ ] Raw sprouts
    - [ ] Raw or undercooked tofu
    - [ ] Refrigerated pate or meat spreads or refrigerated smoked seafood
    - [ ] Hot dogs, lunchmeats, and other deli meats **not reheated to steaming hot**
    - [ ] Michigan fish
    - [ ] None apply
13. Do you or have you? (Check all that apply):
    - [ ] Eat a strict vegetarian diet
    - [ ] Eat a low calorie/weight loss diet
    - [ ] Had bariatric surgery
    - [ ] Eat a low-carbohydrate, high protein diet (like Atkins, etc.)
    - [ ] Eat little food because of stomach surgery to lose weight
    - [ ] Regularly eat non-food items (ashes, carpet fibers, cigarettes or cigarette butts, clay, dust, foam rubber, paint chips, soil, laundry or corn starch)
    - [ ] Take a vitamin or mineral supplement daily  - [ ] What kind?
    - [ ] Take an iodine supplement daily
    - [ ] Use herbal supplement remedies or teas  - [ ] What kind?
    - [ ] Take a fluoride supplement
    - [ ] None apply
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