

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? <input type="checkbox"/> Married <input type="checkbox"/> Unmarried
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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.

Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you Arabic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Check all races that apply to you: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White
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Pregnancy Information

What was the date of your last menstrual period? Month/Day/Year _____	When is your baby due? Month/Day/Year _____
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What was your weight just before you became pregnant with this baby? (CDC)
_____ pounds

- How many times have you been pregnant? _____ How many live babies have you had? _____
(Count any abortions, miscarriages or stillbirths)
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)
- 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
- 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
- How many times have you seen your health provider for this pregnancy? _____
Where do you receive your regular prenatal care? _____
- Have you been offered a blood test for HIV? Yes No

6. For any **previous** pregnancies, please check all that occurred:
- | | |
|--|---|
| <input type="checkbox"/> History of Gestational Diabetes (GDM or high blood sugar) | <input type="checkbox"/> History of Preeclampsia (diagnosed pregnancy high blood pressure/hypertension) |
| <input type="checkbox"/> Infant born alive, but died before 1 month | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Premature delivery (36 weeks or less) | <input type="checkbox"/> Infant born with congenital or other birth defects |
| <input type="checkbox"/> Infant weighed 5 pounds, 8 ounces or less at birth | <input type="checkbox"/> Infant weighed 9 pounds or more at birth |
| <input type="checkbox"/> Infant died after 5 months of pregnancy | <input type="checkbox"/> None apply |

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

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 What kind? _____

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

Staff Notes

CPA Signature	Date
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