

Pregnancy Information Tab



1. Including this pregnancy, 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? _____/_____/_____(CDC)
(Date of last delivery, abortion, miscarriage or stillbirth) Month Day Year

2. How many months were you pregnant when you had your first visit for prenatal care from a doctor or a certified nurse midwife? (CDC)

- First month
- Second month
- Third month
- Fourth month
- Fifth month
- Sixth month
- Seventh month
- Eighth or Ninth month
- Unknown
- No Medical Care

3. }
4. } QUESTIONS NUMBER # 3 – 6 DO NOT NEED AN ANSWER
5. }
6. }
2

7. Please check what is true about your most recent pregnancy or delivery (Check all that apply):

- Premature delivery (36 weeks or less) Infant born with spina bifida
- Low birth weight, infant that weighed 5 pounds, 8 ounces or less Infant weighed 9 pounds or more
- Infant born with a birth defect C-Section
- None Apply

8. Please check what is true about any **previous deliveries before this pregnancy**:

- Never pregnant before Infant 9 pounds or more None apply

9. During your most recent pregnancy, were you told by a doctor you had gestational diabetes? (CDC)

- Yes
- No
- Unknown

10. During your most recent pregnancy, did you have high blood pressure? (CDC)

- Yes
- No
- Unknown

11. How many infants resulted from this pregnancy?

(CDC)

- Number of infants (1 – 7)
- 8 or more
- Unknown

12. Was this infant born alive? _____

(CDC)

Note to Staff: Question # 12 on the MI-WIC screen is not reflected exactly by question 12 above. Response to question 12 on the screen may trigger requirement for more information that you will complete on the screen.

Medical Information Tab

1. **Medical conditions**/recent illnesses: WIC Staff will give you a list of medical conditions to review

2. Are you taking any **medicines (prescription or non-prescription) or street drugs?**

(Check if yes):

If yes, what kind?

Any side effects?

Yes

If yes, what?

No

3. Do you have any **dental problems** that make it difficult to eat?

Yes No

If yes, what?

4. Have you taken any vitamins or minerals in the past month?

Yes

No

Unknown

5. Are you consuming folic acid from fortified foods and/or taking a folic acid supplement daily?

Yes No

6. In the last 3 months of your pregnancy, 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?

(CDC)

- 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. During the last 3 months of your pregnancy, 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. 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
- I drank 5 or more drinks in one day in the last month
- I drank 5 or more drinks on 5 or more days in the last month

Nutrition History Screen



1. Have you ever breastfed any children? Yes No

2. NUMBER 2 DOES NOT NEED AN ANSWER

3. Are you currently breastfeeding two children (not twins)? 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** 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)? (Check if yes)
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**? If yes, to what?

11. Do you eat or drink any of the following everyday 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 or 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? (Check all that apply):

- Eat a strict vegetarian diet
- Eat a low calorie/weight loss diet
- 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
- Use herbal supplement remedies or teas What kind
- Take a fluoride supplement
- None apply

Staff Notes

CPA Signature _____ **Date** _____