

POSTPARTUM 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
-----------------	---	---

The following question is optional. Your answer will be used for 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
---	---	--

What was the date of your last menstrual period? Month/Day/Year _____	When was your baby due? Month/Day/Year _____	When was your baby actually born? Month/Day/Year _____
--	---	---

What was your weight just before you became pregnant with this baby? (CDC) _____ pounds	How much weight did you gain during this pregnancy? (CDC) _____ pounds
--	--

Pregnancy Information

1. Including this pregnancy, 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)

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.

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

<input type="checkbox"/> Premature delivery (36 weeks or less)	<input type="checkbox"/> Infant born with spina bifida
<input type="checkbox"/> Low birth weight, 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 born with a birth defect	<input type="checkbox"/> C-Section
<input type="checkbox"/> Preeclampsia	<input type="checkbox"/> None apply
<input type="checkbox"/> Impaired fasting glucose or glucose tolerance	

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

Never pregnant before Infant weighed 9 pounds or more at birth None apply
 History of Preeclampsia (physician diagnosed)

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? Yes No (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

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?**
 Yes No
 If yes, what kind? _____
 Any side effects? Yes No
 If yes, what? _____
3. Do you have any **oral/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 Unknown
6. In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day? (20 cigarettes = 1pack) (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

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 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? _____
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
---------------	------

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

Authority: Act 368 PA 1978	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.
-----------------------------------	--