



**Medical Information Screen**



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

2. Does your child take any **medicines**: (Check if yes)  If yes, what kind?

Any side effects?  Yes If yes, what?   No

3. Was this a:  single birth  triplet birth  
 twin birth  more than 3

4. Mother's Height:  ft  in 5. Mother's Weight:  lb

This should be answered by the **biological mother** only. What is your current height and weight? (OR if you are pregnant now or had a baby in the past 6 months, what was your weight before that pregnancy?)

6. Father's Height:  ft  in 7. Father's Weight:  lb

This should be answered by the **biological father** only.

8. Does anyone living in your **household smoke** inside the home? (CDC)  
 Yes  No  Unknown

9. About how many hours did your child sit and **watch television** or videos yesterday? (CDC)  
 > 0 and < 1 hour  1 hour  2 hours  
 3 hours  4 hours  5 or more hours  
 None  Unknown

**BF Statistics Tab** (CDC)

Was this child ever breastfed or fed breast milk?

- Yes    No    Unknown

Is this child currently breastfed?

- Yes    No

How old was this child when he/she was **first fed** something other than breast milk?

- Exclusively Breastfed (**Check here if child has never had anything except breast milk**)

Age:      Months      Weeks      Days

                  Unknown

Type of Food (Circle One)

- Cereal
- Cow's Milk
- Formula
- Fruit Juice
- No Information Provided
- Vegetable
- Water

**(Answer the next question if your child is no longer getting breast milk)**

How old was this child when he/she completely stopped breastfeeding or being fed breast milk?

Age:      Months      Weeks      Days

                  Unknown

Reason Breastfeeding Ended  
(Circle One)

- Baby distracted
- Breast/Nipple Pain
- Doctor recommended
- Infant/Child Illness/Condition
- Lack of Support
- Latch Issues/Refused Breast
- Low Milk Supply
- Maternal Illness/Surgery
- Medication
- Mother's Preference
- No Information Provided
- Other
- Return to School
- Return to Work
- Teething

**Nutrition History Screen**



1. If breastfed, how old was this child when he/she was **routinely** fed something other than breast milk?

Months     Weeks     Days

Type of Food Choices:     Cereal     Cow's Milk     Formula     Meat  
 Fruit     Juice     Vegetable     Water

2. Has your baby's health care provider/doctor said that your baby has or had:

- Jaundice
- A weak suck
- Poor weight gain
- Good weight gain
- Has inadequate bowel movements for age
- None apply

3. If breastfeeding who ends the nursing session?     Mom     Child

4. Does your infant sometimes take expressed breast milk from a bottle, cup or other?  
(Check if yes):

5. If expressing breast milk, do you feed fresh breast milk stored in the refrigerator for longer than 72 hours?  
 Yes     No

6. Is your infant drinking formula NOW? (Check if yes):

If yes, Formula Name:

7. If feeding formula, how much does your baby usually drink at a feeding?  Ounces

8. If feeding formula, is it stored:

At room temperature more than 2 hours?  Yes  No

In refrigerator more than 48 hours?  Yes  No

9. Do you have access to:

Safe water to prepare formula.  Yes  No

A refrigerator to store formula or breast milk.  Yes  No

10. Which appliances do you use to prepare formula?

Stove/range  Hot plate  Microwave  Other

11. Has your baby been given a bottle of formula or expressed breast milk left over from a previous feeding?

Yes  No

12. Is your infant? (Check all that apply):

Take a bottle to bed, nap or while lying down  Sip from a training cup throughout the day

Drink from a bottle propped up when feeding  Eat Finger foods

Eat from a spoon

Take a vitamin or mineral supplement daily  
What kind

Get cereal or infant food in a bottle/infant feeder  Use herbal supplement remedies or teas  
What kind

Receive sugar water

Have any dental problems

Receive juice in a bottle

Consume a vegetarian diet

Receive soda/pop in a bottle

Follow a special diet  
If yes, what type?

Use a bottle throughout the day as a pacifier

Take fluoride supplement

None apply

13. Does your baby eat or drink anything besides breast milk, formula and water?  Yes  No  
If yes, check what baby eats or drinks:

- |   |  |
|---|--|
| <input type="checkbox"/> Whole/low fat milk         | <input type="checkbox"/> Table Food    |
| <input type="checkbox"/> Imitation milk             | <input type="checkbox"/> Mixed Dinners |
| <input type="checkbox"/> Goat's/sheep's milk        | <input type="checkbox"/> Hot dogs      |
| <input type="checkbox"/> Vegetables                 | <input type="checkbox"/> Coffee/tea    |
| <input type="checkbox"/> Meats                      | <input type="checkbox"/> Candy/cookies |
| <input type="checkbox"/> Fruit                      | <input type="checkbox"/> Ice cream     |
| <input type="checkbox"/> Cereal                     | <input type="checkbox"/> Chips/donuts  |
| <input type="checkbox"/> Teething Biscuits          | <input type="checkbox"/> French Fries  |
| <input type="checkbox"/> Other <input type="text"/> |  |

14. Does your infant have any food allergies? (Check if yes)  If yes, to what?

15. Do you use sugar, honey or syrup on a pacifier?  Yes  No

16. Does your infant eat or drink any of the following? (Check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Raw (unpasteurized) juice or milk                                      | <input type="checkbox"/> Raw or undercooked (rare) meat, fish, poultry or egg                    |
| <input type="checkbox"/> Soft cheese(feta, camembert, Brie, queso blanco, queso fresco, Panela) | <input type="checkbox"/> Raw sprouts or raw or undercooked tofu                                  |
| <input type="checkbox"/> Honey  | <input type="checkbox"/> Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot |
| <input type="checkbox"/> None apply   |  |

17. Did the mother or this infant use alcohol or drugs during pregnancy?  Yes  No

18. Is the mother of this infant mentally impaired?  Yes  No

19. Has your infant been in foster care in the past 6 months?  Yes  No

20. Does a family member have a disability that would make it difficult to plan or prepare food for your baby?

Yes  No

**Staff Notes**

**CPA Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



# Infant - Mid-Certification Health and Diet Questions

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Your baby's name \_\_\_\_\_

## Medical Information Screen



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

2. Does your child take any **medicines**: (Check if yes)  If yes, what kind?

Any side effects?  Yes If yes, what?   No

3. Was this a:  single birth  triplet birth  
 twin birth  more than 3

4. Mother's Height:  ft  in 5. Mother's Weight:  lb

This should be answered by the **biological mother** only. What is your current height and weight? (OR if you are pregnant now or had a baby in the past 6 months, what was your weight before that pregnancy?)

6. Father's Height:  ft  in 7. Father's Weight:  lb

This should be answered by the **biological father** only.

8. Does anyone living in your **household smoke** inside the home? (CDC)

Yes  No  Unknown

9. About how many hours did your child sit and **watch television** or videos yesterday? (CDC)

> 0 and < 1 hour  1 hour  2 hours  
 3 hours  4 hours  5 or more hours  
 None  Unknown

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**BF Statistics Tab**

(CDC)

Was this child ever breastfed or fed breast milk?

- Yes    No    Unknown

Is this child currently breastfed?

- Yes    No

How old was this child when he/she was **first fed** something other than breast milk?

- Exclusively Breastfed (**Check here if child has never had anything except breast milk**)

Age:      Months      Weeks      Days

                  Unknown

Type of Food (Circle One)

Cereal
Cow's Milk
Formula
Fruit Juice
No Information Provided
Vegetable
Water

**(Answer the next question if your child is no longer getting breast milk)**

How old was this child when he/she completely stopped breastfeeding or being fed breast milk?

Age:      Months      Weeks      Days

                  Unknown

Reason Breastfeeding Ended (Circle One)

Baby distracted
Breast/Nipple Pain
Doctor recommended
Infant/Child Illness/Condition
Lack of Support
Latch Issues/Refused Breast
Low Milk Supply
Maternal Illness/Surgery
Medication
Mother's Preference
No Information Provided
Other
Return to School
Return to Work
Teething

**Nutrition History Screen**



1. If breastfed, how old was this child when he/she was **routinely** fed something other than breast milk?

Months

Weeks

Days

Type of Food Choices:     Cereal     Cow's Milk     Formula     Meat  
 Fruit     Juice     Vegetable     Water

2. Has your baby's health care provider/doctor said that your baby has or had:

- Jaundice
- A weak suck
- Poor weight gain
- Good weight gain
- Has inadequate bowel movements for age
- None apply

3. If breastfeeding who ends the nursing session?     Mom     Child

4. Does your infant sometimes take expressed breast milk from a bottle, cup or other?  
(Check if yes):

5. If expressing breast milk, do you feed fresh breast milk stored in the refrigerator for longer than 72 hours?  
 Yes     No

6. Is your infant drinking formula NOW? (Check if yes):

If yes, Formula Name:

7. If feeding formula, how much does your baby usually drink at a feeding?  Ounces

8. If feeding formula, is it stored:

At room temperature more than 2 hours?  Yes  No

In refrigerator more than 48 hours?  Yes  No

9. Do you have access to:

Safe water to prepare formula?  Yes  No

A refrigerator to store formula or breast milk ?  Yes  No

10. Which appliances do you use to prepare formula?  Stove/range  Hot plate  Microwave  Other

11. Has your baby been given a bottle of formula or expressed breast milk left over from a previous feeding?

Yes  No

12. Does your infant? (Check all that apply):

Take a bottle to bed, nap or while lying down  Sip from a training cup throughout the day

Drink from a bottle propped up when feeding  Eat Finger foods

Eat from a spoon  Take a vitamin or mineral supplement daily  
What kind

Get cereal or infant food in a bottle/infant feeder  Use herbal supplement remedies or teas  
What kind

Receive sugar water  Have any dental problems

Receive juice in a bottle  Consume a vegetarian diet

Receive soda/pop in a bottle  Follow a special diet  
If yes, what type?

Use a bottle throughout the day as a pacifier  Take fluoride supplement

None apply

13. Does your baby eat or drink anything besides breast milk, formula and water?  Yes  No  
If yes, check what baby eats or drinks:

- |   |  |
|---|--|
| <input type="checkbox"/> Whole/low fat milk         | <input type="checkbox"/> Table Food    |
| <input type="checkbox"/> Imitation milk             | <input type="checkbox"/> Mixed Dinners |
| <input type="checkbox"/> Goat's/sheep's milk        | <input type="checkbox"/> Hot dogs      |
| <input type="checkbox"/> Vegetables                 | <input type="checkbox"/> Coffee/tea    |
| <input type="checkbox"/> Meats                      | <input type="checkbox"/> Candy/cookies |
| <input type="checkbox"/> Fruit                      | <input type="checkbox"/> Ice cream     |
| <input type="checkbox"/> Cereal                     | <input type="checkbox"/> Chips/donuts  |
| <input type="checkbox"/> Teething Biscuits          | <input type="checkbox"/> French Fries  |
| <input type="checkbox"/> Other <input type="text"/> |  |

14. Does your infant have any food allergies? (Check if yes)  If yes, to what?

15. Do you use sugar, honey or syrup on a pacifier?  Yes  No

16. Does your infant eat or drink any of the following? (Check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Raw (unpasteurized) juice or milk                                       | <input type="checkbox"/> Raw or undercooked (rare) meat, fish, poultry or egg                    |
| <input type="checkbox"/> Soft cheese (feta, camembert, brie, queso blanco, queso fresco, panela) | <input type="checkbox"/> Raw sprouts or raw or undercooked tofu                                  |
| <input type="checkbox"/> Honey   | <input type="checkbox"/> Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot |
| <input type="checkbox"/> None apply  |  |

17. Did the mother or this infant use alcohol or drugs during pregnancy?  Yes  No
18. Is the mother of this infant mentally impaired?  Yes  No
19. Has your infant been in foster care in the past 6 months?  Yes  No
20. Does a family member have a disability that would make it difficult to plan or prepare food for your baby?  Yes  No

**Staff Notes**

**CPA Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**Medical Information Screen**



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

2. Check here if your child takes any **medicines**:  If yes, what kind?

Any side effects?  Yes  No

3. Does your child have any **dental problems** that make it difficult to eat?  Yes  No

If yes, what kind?

4. Mother's Height:  ft  in 5. Mother's Weight:  lb

This should be answered by the **biological mother** only. What is your current height and weight? (OR if you are pregnant now or had a baby in the past 6 months, what was your weight before that pregnancy?)

6. Father's Height:  ft  in 7. Father's Weight:  lb

This should be answered by the **biological father** only.

8. Does anyone living in your **household smoke** inside the home? (CDC)

Yes  No  Unknown

9. About how many hours did your child sit and **watch television** or videos yesterday? (CDC)

- > 0 and < 1 hour  1 hour
- 2 hours  3 hours
- 4 hours  5 or more hours
- None  Unknown

**BF Statistics Tab** (CDC)

Was this child ever breastfed or fed breast milk?

- Yes    No    Unknown

Is this child currently breastfed?

- Yes    No

How old was this child when he/she was **first fed** something other than breast milk?

- Exclusively Breastfed (**Check here if child has never had anything except breast milk**)

Age:      Months      Weeks      Days  
           

- Unknown

Type of Food (Circle One)

- Cereal
- Cow's Milk
- Formula
- Fruit Juice
- No Information Provided
- Vegetable
- Water

**(Answer the next question if your child is no longer getting breast milk)**

How old was this child when he/she completely stopped breastfeeding or being fed breast milk?

Age:      Months      Weeks      Days  
           

- Unknown

Reason Breastfeeding Ended  
(Circle One)

- Baby distracted
- Breast/Nipple Pain
- Doctor recommended
- Infant/Child Illness/Condition
- Lack of Support
- Latch Issues/Refused Breast
- Low Milk Supply
- Maternal Illness/Surgery
- Medication
- Mother's Preference
- No Information Provided
- Other
- Return to School
- Return to Work
- Teething

**Nutrition History Screen**



1. If breastfed, how old was this child when he/she was **routinely** fed something other than breast milk?

Months       Weeks       Days

Type of Food Choices:     Cereal     Cow's Milk     Formula     Meat  
                                   Fruit       Juice             Vegetable    Water

2. Number of **Meals** your child usually eats in a day:  
 0     1     2     3     4     5 or more

3. Number of **Snacks** your child usually eats in a day:  
 0     1     2     3     4     5 or more

4. How many ounces of **milk** does your child drink most days?

5. How many ounces of **juice** does your child drink most days?

6. Is your child's **appetite** usually:     Good     Fair     Poor

7. Check here if your child is on a **special diet**:     If yes, what kind?

8. How many times a week does your child eat **Fast Food**?  
 0     1     2     3     4     5 or more

9. Does your child have any **food allergies**? If yes, to what?

10. Does your child eat or drink any of the following every day or most days? (Check all that apply):

- Skim, ½%, 1% or 2%
- Pop, Koolaid, Sports drinks, flavored water, sweet tea, Jell-O water
- Milk substitutes (rice milk, soy milk, non-dairy creamer, sweetened condensed milk or homemade milks)
- Baby food or blenderized food only
- None apply

11. Does your child eat or drink any of the following? (Check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Raw (unpasteurized) juice or milk                                       | <input type="checkbox"/> Raw sprouts/tofu   |
| <input type="checkbox"/> Soft cheese (feta, camembert, Brie, queso blanco, queso fresco, Panela) | <input type="checkbox"/> Hot dogs, lunchmeats, and other deli meats <u>not reheated to steaming hot</u> |
| <input type="checkbox"/> Raw or undercooked (rare) meat, fish, poultry or eggs                   | <input type="checkbox"/> Michigan fish  |
| <input type="checkbox"/> None apply  |   |

12. Does your child? (Check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Use a bottle                                      | <input type="checkbox"/> Drink juice in a bottle                              |
| <input type="checkbox"/> Sleep with a bottle                               | <input type="checkbox"/> Sip from a training or sippy cup <u>all day long</u> |
| <input type="checkbox"/> Use a bottle all through the day or as a pacifier | <input type="checkbox"/> Use a pacifier dipped in sugar, honey or syrup       |
| <input type="checkbox"/> Take cereal or other food in a bottle             | <input type="checkbox"/> None apply   |

13. Does your child? (Check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Eat a strict vegetarian diet  | <input type="checkbox"/> Choke on his/her food often  |
| <input type="checkbox"/> Eat a low calorie/weight loss diet  | <input type="checkbox"/> Take a fluoride supplement daily   |
| <input type="checkbox"/> Regularly eat non-food items (ashes, carpet fibers, cigarettes or cigarette butts, clay, dust foam rubber, paint chips, soil, laundry or corn starch) | <input type="checkbox"/> Take a vitamin/mineral supplement daily<br>What kind? <input type="text"/> |
| <input type="checkbox"/> Have to eat when he/she doesn't want to   | <input type="checkbox"/> Use herbal supplement remedies or teas<br>What kind? <input type="text"/>  |
| <input type="checkbox"/> Eat only by being spoon-fed (child never feeds self with spoon, fingers, etc.)  | <input type="checkbox"/> None apply   |

14. Has your child been in **foster care** in the past 6 months?  Yes  No

15. Does a family member have a **disability** that would make it difficult to plan or prepare food for your child?  Yes  No

**Staff Notes**

**CPA Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



## Pregnant Woman's Health and Diet Questions

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Your name: \_\_\_\_\_

How many grades of school have you completed? \_\_\_\_\_

Are you currently: \_\_\_\_ married \_\_\_\_ not married

**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?       Yes    No

Are you Arabic?       Yes    No

Check **all** races that apply to you:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

What is the date of your last menstrual period? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

When is your baby due? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

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

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**Pregnancy Information Tab**



1. 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? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (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. For this pregnancy (check all that apply):

- Some **weight loss** during pregnancy
- Severe **Nausea and Vomiting**
- Gestational Diabetes Mellitus**
- Expecting to deliver **twins or more**
- Fetal Growth Restriction** (Intrauterine Growth Retardation)
- High blood pressure because of this pregnancy**
- None Apply

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

5. Check here if you have been offered a blood test for HIV?

6. Please check which is true about any **previous** deliveries or pregnancies:

- History of Gestational Diabetes
- Infant born alive, but died before 1 month
- Premature delivery (36 weeks or less)
- Miscarriage
- Delivered an infant that weighed 5 pounds, 8 ounces or less
- Infant born with congenital or other birth defects
- Infant died after 5 months of pregnancy
- Infant weighed 9 pounds or more
- None Apply

**Medical Information Tab**

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

2. Since you became pregnant, have you taken 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. In the month before you got pregnant with this baby, how many times did you take a multivitamin (a pill that contains many 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? (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. 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 Screen**



1. Have you ever breastfed any children?     Yes     No
  
2. Are you currently breastfeeding another child?     Yes     No
  
3. NUMBER 3 DOES NOT NEED AN ANSWER
  
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** \_\_\_\_\_



**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** \_\_\_\_\_



## Postpartum Woman's Health and Diet Questions - A

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Your name: \_\_\_\_\_

How many grades of school have you completed? \_\_\_\_\_

Are you currently: \_\_\_\_ married \_\_\_\_ not married

**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?       Yes    No

Are you Arabic?       Yes    No

Check **all** races that apply to you:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

What was the date of your last menstrual period?: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month   Day   Year

What was your due date? \_\_\_\_/\_\_\_\_/\_\_\_\_      When did your pregnancy end? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month   Day   Year      Month   Day   Year

What was your weight just before you became pregnant? \_\_\_\_\_ pounds      (CDC)

How much weight did you gain during this pregnancy? \_\_\_\_\_ pounds      (CDC)

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**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. }

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)

Please check what is true about your most recent pregnancy or delivery:

- \_\_\_ Miscarriage (before 20 weeks)
- \_\_\_ Pregnancy ended at 20 weeks or after
- \_\_\_ Infant died within first 28 days of life

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If yes, what kind?

Any side effects?

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If yes, what?

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No

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Unknown

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

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No

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- 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** \_\_\_\_\_