



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** _____