PREGNANT WOMAN’S HEALTH AND DIET QUESTIONS
Michigan Department of Health and Human Services

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? Race: Select one or more:
- [ ] Yes
- [ ] No
- [ ] American Indian or Alaska Native
- [ ] White
- [ ] Asian
- [ ] European
- [ ] Black or African American
- [ ] North African
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] Middle Eastern

Pregnancy Information

**What was 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?** (CDC)
____ pounds

1. **How many times have you been pregnant?**
   (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 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

3. **For this pregnancy, check all that apply. I have:**
   - [ ] Some **weight loss** during pregnancy
   - [ ] Severe **nausea and vomiting**
   - [ ] **Gestational Diabetes** (high blood sugar)
   - [ ] **Twins or more expected**
   - [ ] **Fetal Growth Restriction** (Intrauterine Growth Retardation)
   - [ ] **High blood pressure (or preeclampsia)** because of this pregnancy
   - [ ] None apply

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

5. **Where do you receive your regular prenatal care?**

6. **Have you been offered a blood test for HIV?**
   - [ ] Yes
   - [ ] No
6. For any previous pregnancies, please check all that occurred:

- History of Gestational Diabetes (GDM or high blood sugar)
- Preterm delivery (< 37 weeks)
- Early term delivery (37 to < 39 weeks)
- Infant weighed 5 pounds, 8 ounces or less at birth
- Infant died after 5 months of pregnancy
- History of Preeclampsia (diagnosed pregnancy high blood pressure/hypertension)
- Infant born alive, but died before 1 month
- Infant born with congenital or other birth defects
- Infant weighed 9 pounds or more at birth
- 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
    - 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
    - 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
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.