PREGNANT 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?

☐ Married  ☐ Unmarried

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?

☐ Yes  ☐ No

Race: Select one or more:

☐ 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?  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?

(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 for this current/most recent pregnancy?  (CDC)

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

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

Where do you receive your regular prenatal care?

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

_____

5. 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
- □ Miscarriage
- □ 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)?
   - □ 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 kind?
   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
   - □ 8 or more times per week
   - □ Number of times per week (1-7) _____
   - □ 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?
   - □ Did 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  [ ] Drank, but quantity unknown
   [ ] Number of drinks per week (1 - 20)  [ ] Unknown or refused
   [ ] 21 or more drinks per week

10. Have you had any alcoholic drinks during this pregnancy?  [ ] Yes  [ ] No

11. Are you currently (check all that apply)?
   [ ] Using any illegal substance  [ ] Using marijuana in any form
   [ ] Abusing any prescription medications  [ ] None

12. Any other physical disability, mental health condition or intellectual disability limiting ability to make appropriate feeding decisions and/or prepare food?  [ ] Yes  [ ] No

Nutrition History

1. Have you ever breastfed any children?  [ ] Yes  [ ] No

2. Are you currently breastfeeding another child under age one?  [ ] Yes  [ ] No

3. Are you currently breastfeeding more than one child?  [ ] 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 (prescribe 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  what kind?
    [ ] Pop or other sweetened beverages  [ ] Whole grains
    [ ] Sweets or salty snacks  [ ] 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 supplemental daily
- □ Use herbal supplement remedies or teas
  What kind?
- □ Take a fluoride supplement
- □ None apply

14. Did you provide MIHP Services for this client during this visit?  □ Yes  □ No

Staff Notes

CPA Signature

Date

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