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?	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? 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
   - ☐ 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?
   _____

   Where do you receive your regular prenatal care?
   _____

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
   - ☐ 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?
   - ☐ 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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