POS PARTUM 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?  When is your baby due?

Month/Day/Year  Month/Day/Year

When was your baby actually born?  What was your weight just before you became pregnant with this baby?  (CDC) pounds

Month/Day/Year  pounds

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

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?

   (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  Sixth month
   Second month  Seventh month
   Third month  Eighth or Ninth month
   Fourth month  Unknown
   Fifth month  No Medical Care

QUESTIONS NUMBER 3- 6 DO NOT NEED AN ANSWER

7. Please check what is true about your most recent pregnancy or delivery (check all that apply):

   Preterm delivery (< 37 weeks)  Preeclampsia
   Early term delivery (37 to < 39 weeks)  Infant born with spina bifida
   Low birth weight, Infant weighed 5 pounds, 8 ounces or less at birth  Infant weighed 9 pounds or more at birth
   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 weighed 9 pounds or more at birth
- [ ] History of Preeclampsia (physician diagnosed)
- [ ] 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. What this infant born alive?  
    (CDC)
- [ ] Yes
- [ ] No

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

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)?
   - [ ] Yes
   - [ ] No
   - [ ] 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?

4. Have you taken any vitamins or minerals in the past month?  
   (CDC)
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

5. Are you consuming folic acid from fortified foods and/or taking a folic acid supplement daily?
   - [ ] 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
   - [ ] Smoked, but quantity unknown
   - [ ] Number of Cigarettes per day (1 - 96) ______
   - [ ] Unknown or refused
   - [ ] 97 or more cigarettes per day

7. How many cigarettes do you smoke on an average day now?  
   (CDC)
   - [ ] Did not smoke
   - [ ] Smoked, but quantity unknown
   - [ ] Number of Cigarettes per day (1 - 96) ______
   - [ ] Unknown or refused
   - [ ] 97 or more cigarettes per day

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
   - Drank, but quantity unknown
   - Number of drinks per week (1 - 20) ______
   - Unknown or refused
   - 21 or more drinks per week

10. Please check what is true about your drinking habits:
   - I do not drink
   - I drank 5 or more drinks in one day in the last month
   - I drank less than two alcoholic beverages per day
   - I drank 5 or more drinks on 5 or more days in the last month
   - I drink two or more drinks per day

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

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**Nutrition History**

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 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
    - 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
- [ ] Take a vitamin or mineral supplement daily
  What kind?
- [ ] Eat a low calorie/weight loss diet
- [ ] Take an iodine supplemental daily
- [ ] Had bariatric surgery
- [ ] Use herbal supplement remedies or teas
  What kind?
- [ ] Eat a low-carbohydrate, high protein diet (like Atkins, etc.)
- [ ] Take a fluoride supplement
- [ ] Eat little food because of stomach surgery to lose weight
- [ ] None apply
- [ ] Regularly eat non-food items (ashes, carpet fibers, cigarettes or cigarette butts, clay, dust, foam rubber, paint chips, soil, laundry or corn starch)

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

Staff Notes

CPA Signature                                    Date

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