# POSPARTUM WOMAN’S HEALTH AND DIET QUESTIONS - A
Michigan Department of Health and Human Services

**Today’s Date**

**Your Name**

<table>
<thead>
<tr>
<th>How many grades of school have you completed?</th>
<th>Are you currently?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Married □ Unmarried</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Are you Hispanic or Latino?</th>
<th>Race: Select one or more:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td>□ American Indian or Alaska Native □ White</td>
</tr>
<tr>
<td></td>
<td>□ Asian                  □ European</td>
</tr>
<tr>
<td></td>
<td>□ Black or African American □ North African</td>
</tr>
<tr>
<td></td>
<td>□ Native Hawaiian or Other Pacific Islander □ Middle Eastern</td>
</tr>
</tbody>
</table>

### Pregnancy Information

<table>
<thead>
<tr>
<th>What was the date of your last menstrual period?</th>
<th>When is your baby due?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month/Day/Year__________________</td>
<td>Month/Day/Year__________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When did your pregnancy end?</th>
<th>Month/Day/Year__________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was your weight just before you became pregnant with this baby?</td>
<td>(CDC) _____ pounds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How much weight did you gain during this pregnancy? (CDC)</th>
<th>_____ pounds</th>
</tr>
</thead>
</table>

1. Including this pregnancy, how many times have you been pregnant? (Count any abortions, miscarriages or stillbirths) □ 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)

<table>
<thead>
<tr>
<th>First month</th>
<th>Sixth month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second month</td>
<td>Seventh month</td>
</tr>
<tr>
<td>Third month</td>
<td>Eighth or Ninth month</td>
</tr>
<tr>
<td>Fourth month</td>
<td>Unknown</td>
</tr>
<tr>
<td>Fifth month</td>
<td>No Medical Care</td>
</tr>
</tbody>
</table>

### 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)
- □ Early term delivery (37 to < 39 weeks)
- □ Low birth weight, infant weighed 5 pounds, 8 ounces or less at birth
- □ Infant born with a birth defect
- □ Preeclampsia
- □ Infant born with spina bifida
- □ Infant weighed 9 pounds or more at birth
- □ 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 is this infant born alive?  
    (CDC)  
    - Yes  
    - No  

   Please check what is true about your most recent pregnancy or deliver:  
   - Miscarriage (before 20 weeks)  
   - Pregnancy ended at 20 weeks or after  
   - Infant died within first 28 days of life  

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

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 5 or more drinks on 5 or more days in the last month
    - I drink less than two alcoholic beverages per day
    - 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

**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
   - [ ] 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
   - [ ] 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**

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