POSPARTUM WOMAN'S HEALTH AND DIET QUESTIONS - A

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_____
When did your pregnancy end? Month/Day/Year_____	
What was your weight just before you became pregnant with this baby? (CDC) _____ 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
   - ☐ Second month
   - ☐ Third month
   - ☐ Fourth month
   - ☐ Fifth month
   - ☐ Sixth month
   - ☐ Seventh month
   - ☐ Eighth or Ninth month
   - ☐ Unknown
   - ☐ 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)
   - ☐ 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 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

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
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? _____

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 drink less than two alcoholic beverages per day
☐ I drink two or more drinks per day
☐ 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

11. Are you currently (check all that apply)?

☐ Using any illegal substance
☐ Abusing any prescription medications
☐ Using marijuana in any form
☐ 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 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
- ☐ 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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