

POSTPARTUM 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: <input type="checkbox"/> Married <input type="checkbox"/> Unmarried
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The following question is optional. Your answer will be used for 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race: Select one or more: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> European <input type="checkbox"/> Black or African American <input type="checkbox"/> North African <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Middle Eastern
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What was the date of your last menstrual period? Month/Day/Year _____	What was your due date? Month/Day/Year _____	When did your pregnancy end? Month/Day/Year _____
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What was your weight just before you became pregnant? (CDC) _____ pounds	How much weight did you gain during this pregnancy? (CDC) _____ pounds
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Pregnancy Information

1. Including this pregnancy, how many times have you been pregnant? (Count any abortions, miscarriages or stillbirths) _____ How many times have you been pregnant for 20 weeks or more before this pregnancy? (CDC) <input type="checkbox"/> None <input type="checkbox"/> Number of pregnancies _____ <input type="checkbox"/> Unknown If you have been pregnant before, when did your last pregnancy end? Month/Day/Year _____ (CDC) (Date of last delivery, abortion, miscarriage or stillbirth)	How many live babies have you had? _____
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) <input type="checkbox"/> First month <input type="checkbox"/> Second month <input type="checkbox"/> Third month <input type="checkbox"/> Fourth month <input type="checkbox"/> Fifth month <input type="checkbox"/> Sixth month <input type="checkbox"/> Seventh month <input type="checkbox"/> Eighth or Ninth month <input type="checkbox"/> Unknown <input type="checkbox"/> No Medical Care	

3.	QUESTIONS NUMBER 3 – 6 DO NOT NEED AN ANSWER
4.	
5.	
6.	

7. Please check what is true about your most recent pregnancy or delivery (check all that apply): <input type="checkbox"/> Preterm delivery (< 37 weeks) <input type="checkbox"/> Infant born with spina bifida <input type="checkbox"/> Early term delivery (37 to < 39 weeks) <input type="checkbox"/> Infant weighed 9 pounds or more at birth <input type="checkbox"/> Low birth weight, infant weighed 5 pounds, 8 ounces or less at birth <input type="checkbox"/> C-Section <input type="checkbox"/> Infant born with a birth defect <input type="checkbox"/> None apply <input type="checkbox"/> Preeclampsia	
8. Please check what is true about any previous deliveries before this pregnancy : <input type="checkbox"/> Never pregnant before <input type="checkbox"/> Infant weighed 9 pounds or more at birth <input type="checkbox"/> None apply <input type="checkbox"/> History of Preeclampsia (physician diagnosed)	

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. Was this infant born alive? Yes No (CDC)
Please check what is true about your most recent pregnancy or delivery:
- 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) or street drugs**?
- Yes No
If yes, what kind? _____
- Any side effects? Yes No
If yes, what? _____
3. Do you have any **oral/dental problems** that make it difficult to eat?
- Yes No
If yes, what? _____
4. Have you taken any vitamins or minerals in the past month?
- 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 last 3 months of your pregnancy, how many cigarettes did you smoke on an average day? (20 cigarettes = 1pack) (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? (CDC)
- Do 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. 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

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** (prescribed 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? _____
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 supplement daily

Use herbal supplement remedies or teas What kind? _____

Take a fluoride supplement

None apply

Staff Notes

CPA Signature	Date
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