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? _____ pounds	

1. Number of pregnancies (including this pregnancy) _____

1a. Number of live babies (not including this pregnancy) _____

How many times have you been pregnant for 20 weeks or more before this pregnancy?

☐ None ☐ Number of pregnancies _____ ☐ Unknown

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?

☐ 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.

☐ Weight loss
☐ Nausea and vomiting
☐ Gestational Diabetes Mellitus
☐ Twins or more expected
☐ Fetal Growth Restriction
☐ High blood pressure
☐ None apply

4. How many times have you seen your health provider for this pregnancy? _____

5. Have you been offered a blood test for HIV? ☐ Yes ☐ No

6. For any **previous** pregnancies, please check all that occurred:

☐ History of GDM
☐ Preterm delivery (< 37 weeks)
☐ Early term delivery (37 to < 39 weeks)
☐ Infant 5 pounds, 8 ounces or less
☐ Infant died after 5 months of PG
☐ History of Preeclampsia
☐ Infant born alive, but died before 1 month
☐ Miscarriage
☐ Congenital/birth defects
☐ Infant 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.
2. **Medications** (prescription or non-prescription)?
   ☐ Yes ☐ No
   If yes, what kind? _____
   Any side effects? ☐ Yes ☐ No
   If yes, what kind? _____
3. **Dental problems** affecting eating?
   ☐ Yes ☐ No
   If yes, what kind? _____
4. In the month before this pregnancy, how many times did you take a multivitamin?
   ☐ Less than once per week ☐ 8 or more times per week
   ☐ Number of times per week (1-7) _____ ☐ Unknown
5. Have you taken any vitamins or minerals in the past month?
   ☐ 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)
   ☐ Do 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?
   ☐ Do 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?
   ☐ 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?
   ☐ Did not drink ☐ Drank, but quantity unknown
   ☐ Number of drinks per week (1 - 20) _____ ☐ Unknown or refused
   ☐ 21 or more drinks per week
10. Alcohol during 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

Breastfeeding Information

1. Have you ever breastfed or pumped breast milk to feed any of your children? ☐ Yes ☐ No
2. Are you currently breastfeeding or pumping breast milk? ☐ Yes ☐ No
   a. Is the baby less than one year old? Infant ID_____ ☐ Yes ☐ No
   b. Are you breastfeeding or pumping milk for more than one child? ☐ Yes ☐ No
      ☐ i. From same pregnancy (multiples)? ☐ ii. From different pregnancies?
3. Did you breastfeed as long as you desired? ☐ Yes ☐ No
   a. If no, Why?

☐ My baby had difficulty latching or nursing
☐ Breast milk alone did not satisfy my baby
☐ I thought my baby was not gaining enough weight
☐ My nipples were sore, cracked or bleeding or it was too painful
☐ I thought I was not producing enough milk, or my milk dried up
☐ I had too many other household duties
☐ I felt it was the right time to stop breastfeeding
☐ I got sick or I had to stop for medical reasons
☐ I went back to work
☐ I went back to school
☐ Lack of support
☐ My baby had an illness or medical condition
☐ Doctor recommended I supplement or wean
☐ Other _____

4. What have you heard about breastfeeding?
5. How are you thinking of feeding your baby?

☐ I want to nurse my baby from the breast
☐ I want to pump and nurse from the breast
☐ I want to pump only
☐ I want to provide both formula and breast milk
☐ I don't want to breastfeed
☐ I don't know
☐ Other

What is your breastfeeding goal?

_____

6. Are you interested in receiving more information about breastfeeding? ☐ Yes ☐ No

Breastfeeding Assessment

1. Are you worried about being able to breastfeed because of any medical conditions or medications: (if any of these boxes are checked, provide anticipatory guidance and referral to CLS/CLS/IBCLC)

☐ Breast Surgery/Trauma
☐ Hypothyroidism
☐ Diabetes
☐ PCOS
☐ Medications
☐ Depression
☐ HIV (Do NOT ask. Only checked if voluntarily shared by client)
☐ No Concerns
☐ Other _____

Nutrition History

1. Number of meals per day
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

2. Number of snacks per day
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

3. Milk per day
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

4. Appetite
☐ Good ☐ Fair ☐ Poor

5. A special diet
☐ Yes ☐ No
If yes, what kind? _____

6. Fast Food per week
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

7. Food allergies
☐ Yes ☐ No
If yes, what kind? _____

8. Consume every day or most days?
☐ Milk what kind? _____
☐ Pop or other sweetened beverages
☐ Sweets or salty snacks
☐ Whole grains
☐ Fruits and vegetables

9. Check all that apply
☐ Unpasteurized juice or milk
☐ Soft cheese
☐ Raw/undercooked meat, fish, poultry or eggs
☐ Raw sprouts
☐ Refrigerated pate/meat spreads
☐ Hot dogs/lunchmeats
☐ Michigan fish
☐ None apply

10. Check all that apply
☐ Vegetarian diet
☐ Low calorie/weight loss diet
☐ Low-carbohydrate, high protein diet
☐ Bariatric surgery
☐ PICA
☐ Vitamin/mineral/Iodine supplement daily
What kind? _____
☐ Herbal supplement remedies/teas
What kind? _____
☐ Fluoride
☐ None apply

11. Did you provide MIHP Services for this client during this visit? ☐ Yes ☐ No

Staff Notes

CPA Signature	Date

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