POSTPARTUM 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___________________	What was your baby's due date? Month/Day/Year___________________
When was your baby actually born?	Month/Day/Year___________________
What was your weight just before you became pregnant with this baby? ______ pounds	
How much weight did you gain during this pregnancy (Weight at delivery)? ______ 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?

- ☐ First month
- ☐ Second month
- ☐ Third month
- ☐ Fourth month
- ☐ Fifth month
- ☐ Sixth month
- ☐ Seventh month
- ☐ Eighth or Ninth month
- ☐ Unknown
- ☐ No Medical Care

3. 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

4. **Previous deliveries**:

- ☐ Never pregnant before
- ☐ Infant weighed 9 pounds or more at birth
- ☐ None apply

5. During your most recent pregnancy, were you told by a doctor you had gestational diabetes?

☐ Yes ☐ No ☐ Unknown

6. During your most recent pregnancy, did you have high blood pressure?
☐ Yes ☐ No ☐ Unknown

7. How many infants resulted from this pregnancy?
☐ Number of infants (1-7) ☐ 8 or more ☐ Unknown

8. Was this infant born alive?
☐ Born alive ☐ Born Dead ☐ Unknown

Note to Staff: Question #12 on the MI-WIC screen is not reflected exactly by question 8 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 **medications** (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. In the month before you got pregnant with this baby, how many times a week 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. Are you consuming folic acid from fortified foods and/or taking a folic acid supplement daily?
☐ Yes ☐ No ☐ Unknown

7. In the 3 months before you were pregnant, how many cigarettes did you smoke on an average day?
☐ Do not smoke ☐ Smoked, but quantity unknown
☐ Number of Cigarettes per day (1 - 96) _____ ☐ Unknown or refused
☐ 97 or more cigarettes per day

8. In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day?
☐ Do not smoke ☐ Smoked, but quantity unknown
☐ Number of Cigarettes per day (1 - 96) _____ ☐ Unknown or refused
☐ 97 or more cigarettes per day

9. 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

10. Does anyone else living in your household smoke inside the home?
☐ Yes, someone else smokes inside the home
☐ No, no one else smokes inside the home
☐ Unknown

11. In the 3 months before you got pregnant, how many alcoholic drinks did you have in an average week?
- ☐ Did not drink
- ☐ Number of drinks per week (1 - 20) ______
- ☐ 21 or more drinks per week
- ☐ Drank, but quantity unknown
- ☐ Unknown or refused

12. During the last 3 months of your pregnancy, how many alcoholic drinks did you have in an average week?
- ☐ Did not drink
- ☐ Number of drinks per week (1 - 20) ______
- ☐ 21 or more drinks per week
- ☐ Drank, but quantity unknown
- ☐ Unknown or refused

13. Please check what is true about your drinking habits.
- ☐ I do not drink
- ☐ I drink less than 2 alcoholic beverages per day
- ☐ I drink 2 or more drinks per day
- ☐ I drank 5 or more drinks in 1 day in the last month
- ☐ I drank 5 or more drinks on 5 or more days in the last month

14. Are you currently (check all that apply)?
- ☐ Using any illegal substance
- ☐ Abusing any prescription medications
- ☐ Using marijuana in any form
- ☐ None

15. 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

NPP Client

1. Did you ever breastfed or pump breast milk to feed your new baby, even for a short period of time? ☐ Yes ☐ No

2. Had you planned on breastfeeding? ☐ Yes ☐ No

   a. If yes, can you tell me what caused you to stop breastfeeding?
   - ☐ 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 ______________________________

3. Would like help with breastfeeding? ☐ Yes ☐ No

BE/BP Client

4. Are you breastfeeding or pumping milk for more than one child? ☐ Yes ☐ No

   If yes, from same pregnancy (multiples)?

   If yes, from different pregnancies? ______________________________

5. What is your breastfeeding goal?

____

____

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 ____________________
2. Tell me how breastfeeding is going.

   ____

   ____

Nutrition History

1. How many **meals** do you eat most days?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
2. How many **snacks** do you eat most days?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
3. How many times do you **drink milk or eat yogurt or cheese** in a day?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
4. Is your **appetite** usually:
   ☐ Good ☐ Fair ☐ Poor
5. Are you on a **special diet** (prescribe by your doctor)?
   ☐ Yes ☐ No
   If yes, what kind? ____________________
6. How many times a week do you eat **Fast Food**
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
7. Do you have any **food allergies**?
   ☐ Yes ☐ No
   If yes, what kind? ____________________
8. 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
9. 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

10. 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
- ☐ PICA
- ☐ 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

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

Staff Notes

CPA Signature	Date

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