

# WIC Nutrition/Health Assessment

## Postpartum Woman

(Health Goal: Be as healthy as possible during childbearing years and reduce the risk of chronic disease.)

Date \_\_\_\_\_

Name \_\_\_\_\_

Date of birth \_\_\_\_\_

1. Which of these meals/snacks do you usually eat?  
 Breakfast                       Morning snack  
 Lunch                               Afternoon snack  
 Dinner/supper                   Evening snack

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2. Do you skip breakfast, lunch, or dinner/supper 3 or more times per week?  
 Yes                                   No

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3. Do you have any problems with your appetite (never hungry, always hungry, etc.)?  
 Yes                                   No

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4. How many days does your family eat together each week?  
 Never     1-3 days     4-7 days

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5. Does your family watch TV during family mealtime?  
 Always     Sometimes     Never

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6. Do you prepare any of your family's meals?  
 Yes                                   No

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7. Do you eat or take a meal from a fast-food restaurant 2 or more times per week?  
 Yes                                   No

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8. Do you have any physical or other limitations that make it difficult for you to plan or prepare meals?  
 Yes                                   No

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9. Do you have a working stove, oven, and refrigerator where you live?  
 Yes                                   No

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10. Were there any days last month when your family did not have enough food to eat or enough money to buy food?  
 Yes                                   No

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11. Are you concerned about your weight?  
 Yes                                   No

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12. Are you on a diet to lose weight?  
 Yes                                   No

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13. Have you used starvation, diet pills, laxatives, or vomiting as a method to lose weight in the past 12 months?  
 Yes                                   No

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14. Have you ever had gastric bypass, stomach stapling, or banding surgery?  
 Yes                                   No  
If yes, when and what type?

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15. Are you on a special diet? Describe.  
 Yes                                   No

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16. Are you a vegetarian?  
 Yes                                   No

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17. Are you lactose intolerant?  
 Yes                                   No

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18. Are you often constipated or have problems with bowel movements?  
 Yes                                   No

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19. How many glasses of water do you drink daily?  
 None                                   4-7  
 1-3                                       8 or more

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20. Do you eat or crave non-food items like clay, laundry starch, paint chips, paper, dirt, or ice?  
 Yes                                   No

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21. How often do you exercise, such as walking for 20-30 minutes without stopping?  
 Daily                                   Once a month  
 3-5 times/week                   Never  
 Once a week

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22. How many hours per day do you spend watching TV or videos or using the computer?  
 0                                       3-4                                   7 or more  
 1-2                                    5-6

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23. Are you currently breastfeeding this baby?  
 Yes                                   No  
If yes, are there any breast problems or problems with breastfeeding?  
 Yes                                   No  
If breastfeeding, do you know your HIV status, or have you discussed this with your doctor?  
 Yes                                   No

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24. Do you receive regular medical care?  
 Yes                                   No

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25. Have you discussed family planning options with your doctor?  
 Yes                                   No

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26. Do you receive regular dental care (visit a dentist)?  
 Yes                                   No

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27. Did your last baby weigh less than or equal to 5 pounds 8 ounces or was 3 or more weeks early?  
 Yes                                   No

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28. Did your last baby weigh 9 pounds or more at birth?  
 Yes                                   No

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29. Did your last baby have a congenital birth defect like neural tube defect, cleft palate, or cleft lip?  
 Yes                                   No

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30. Did you have gestational diabetes with your most recent pregnancy?  
 Yes                                   No

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31. Are you taking a vitamin/mineral supplement (like prenatal vitamins or a supplement with 400 mcg folic acid) or an herbal supplement?  
 Yes                                   No

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32. Do you ever use street drugs (marijuana/speed/crack/heroin/meth/etc.)?  
 Yes                                   No

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33. Do you eat any of the following:  
 Raw or undercooked meat, fish, poultry, or eggs  
 Unpasteurized milk/soft cheeses  
 Unheated lunch meats, hot dogs, or other processed meats  
 Raw sprouts  
 Unpasteurized juice  
 Raw or undercooked tofu  
 None

***This institution is an equal opportunity provider.***

Name \_\_\_\_\_

Date of birth \_\_\_\_\_

34. Which of these foods/beverages do you normally eat or drink?

35. Do you currently have any of the following as **diagnosed by a primary care provider**:

**Grains**

- Bread
- Rolls
- Bagels
- Muffins
- Popcorn
- Noodles/pasta/rice
- Tortillas
- Crackers
- Cereal/grits

**Vegetables**

- Corn
- Peas
- Potatoes
- French fries
- Greens (collard, spinach)
- Vegetable/tomato juice
- Green salad
- Broccoli/cauliflower
- Green beans
- Carrots
- Tomatoes
- Sweet potatoes
- Green chile/green pepper

**Fruits**

- Apples
- Oranges
- Grapefruit
- Grapes
- Berries
- 100% Fruit juice
- Bananas
- Pears/plums
- Melon
- Peaches
- Plums

**Milk and Other Dairy Products**

- Fat-free (skim) milk
- Low-fat (½ –1%) milk
- Reduced-fat (2%) milk
- Whole milk
- Flavored milk
- Cheese
- Yogurt
- Cottage cheese
- Ice cream
- Unfortified or imitation milk

**Meat and Meat Alternatives**

- Beef/hamburger
- Pork
- Chicken
- Turkey
- Fish
- Cold cuts (hot dogs, lunch meat)
- Sausage
- Peanut butter/nuts
- Eggs
- Dried beans/peas
- Tofu

**Fats and Sweets**

- Margarine/butter
- Lard/shortening
- Gravy
- Bacon
- Chips
- Doughnuts/pastries
- Pie
- Cake/cupcakes
- Jell-o

**Other Beverages**

- Regular soft drinks
- Diet soft drinks
- Fruit-flavored drinks
- Coffee/tea
- Sweet tea
- Beer/wine/liquor
- Energy drinks
- Sports drink (like Gatorade)

Problem	Y	N
Dental problems		
Cancer		
Celiac Disease		
Central nervous system disorders like epilepsy, cerebral palsy or spina bifida		
Depression		
Developmental, sensory or motor delays interfering with the ability to eat		
Diabetes		
Eating disorders		
Food allergies List:		
Gastro-Intestinal disorders like ulcers, liver disease, pancreatic problems, or gallbladder disease		
Genetic and congenital disorders like cleft lip, cleft palate, thalassemia major, Down's syndrome, or sickle cell disease		
Hypertension (high blood pressure)		
Hypoglycemia (low blood sugar)		
Inborn errors of metabolism like PKU or galactosemia		
Infectious disease like hepatitis, HIV, TB, or AIDS		
Other medical conditions like lupus, heart disease, cystic fibrosis, or asthma with daily medication		
Recent major surgery (including C-section), accident, or burns		
Renal (kidney) disease		
Thyroid disorders		
Other diagnosed conditions List:		

Signature of person completing this form \_\_\_\_\_

Date \_\_\_\_\_

Relationship to applicant \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

CPA Signature/Title \_\_\_\_\_

Date \_\_\_\_\_