

# 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 \_\_\_\_\_

1. Which of these meals/snacks do you usually eat?  
 Breakfast                       Morning snack  
 Lunch                                 Afternoon snack  
 Dinner/supper                       Evening snack
2. Do you skip breakfast, lunch, or dinner/supper 3 or more times per week?  
 Yes                                       No
3. Do you have any problems with your appetite (never hungry, always hungry, etc.)?  
 Yes                                       No
4. How many days does your family eat together each week?  
 Never     1-3 days     4-7 days
5. Does your family watch TV during family mealtime?  
 Always     Sometimes     Never
6. Do you prepare any of your family's meals?  
 Yes                                       No
7. Do you eat or take a meal from a fast-food restaurant 2 or more times per week?  
 Yes                                       No
8. Do you have any physical or other limitations that make it difficult for you to plan or prepare meals?  
 Yes                                       No
9. Do you have a working stove, oven, and refrigerator where you live?  
 Yes                                       No
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
11. Are you concerned about your weight?  
 Yes                                       No
12. Are you on a diet to lose weight?  
 Yes                                       No
13. Have you used starvation, diet pills, laxatives, or vomiting as a method to lose weight in the past 12 months?  
 Yes                                       No
14. Have you ever had gastric bypass, stomach stapling, or banding surgery?  
 Yes                                       No  
If yes, when and what type?
15. Are you on a special diet? Describe.  
 Yes                                       No
16. Are you a vegetarian?  
 Yes                                       No
17. Are you lactose intolerant?  
 Yes                                       No
18. Are you often constipated or have problems with bowel movements?  
 Yes                                       No
19. How many glasses of water do you drink daily?  
 None                                       4-7  
 1-3                                         8 or more

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

20. Do you eat or crave non-food items like clay, laundry starch, paint chips, paper, dirt, or ice?  
 Yes                                       No
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
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
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
24. Do you receive regular medical care?  
 Yes                                       No
25. Have you discussed family planning options with your doctor?  
 Yes                                       No
26. Do you receive regular dental care (visit a dentist)?  
 Yes                                       No
27. Did your last baby weigh less than or equal to 5 pounds 8 ounces or was 3 or more weeks early?  
 Yes                                       No
28. Did your last baby weigh 9 pounds or more at birth?  
 Yes                                       No
29. Did your last baby have a congenital birth defect like neural tube defect, cleft palate, or cleft lip?  
 Yes                                       No
30. Did you have gestational diabetes or preeclampsia with any pregnancy?  
 Yes                                       No
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  
If you are breastfeeding, does the supplement contain at least 150 mcg of iodine?  
 Yes                                       No                                       Unknown
32. Do you ever use street drugs (marijuana/speed/crack/heroin/meth/etc.)?  
 Yes                                       No
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 vegetable sprouts  
 Unpasteurized juice  
 None

**USDA is an equal opportunity provider and employer.**

Name \_\_\_\_\_

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

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

**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
- 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
- Soy 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
- Dry 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)

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

Problem	Y	N
Bariatric surgery		
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, prediabetes		
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), prehypertension		
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 \_\_\_\_\_