WIC Nutrition/Health Assessment

Postpartum Woman

Date _____

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

Name _____ **Date of birth** _____

1. Which of these meals/snacks do you usually eat?
   - ☐ Breakfast
   - ☐ Lunch
   - ☐ Dinner/supper
   - ☐ Morning snack
   - ☐ Afternoon snack
   - ☐ 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 ☐ 1–3 ☐ 4–7 ☐ 8 or more
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 ☐ 3–5 times/week ☐ Once a week ☐ Once a month ☐ Never
22. How many hours per day do you spend watching TV or videos or using the computer?
    - ☐ 0 ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7 or more
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

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 _____