WIC Nutrition/Health Assessment
Pregnant Woman
(Health Goal: Deliver a healthy, full-term infant, and be as healthy as possible.)

Date

Name

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 didn't 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

15. Are you on a special diet?
    - [ ] 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. Have you ever been pregnant before?
    - [ ] Yes
    - [ ] No

24. Do you have medical care for this pregnancy?
    - [ ] Yes
    - [ ] No

25. Do you receive regular dental care (visit a dentist)?
    - [ ] Yes
    - [ ] No

26. Have you ever delivered a baby weighing 5 pounds 8 ounces or less at birth?
    - [ ] Yes
    - [ ] No

27. Have you ever given birth to a baby born at least 3 weeks early?
    - [ ] Yes
    - [ ] No

28. Have you ever delivered a baby who weighed 9 pounds or more at birth?
    - [ ] Yes
    - [ ] No

29. Have you ever had a fetal death (greater than 20 weeks gestation) or delivered a baby who died within 28 days of birth?
    - [ ] Yes
    - [ ] No

30. Has a doctor ever told you that you have gestational diabetes with this pregnancy or with any pregnancy?
    - [ ] Yes
    - [ ] No

31. Has a doctor ever told you that you had preeclampsia in a previous pregnancy?
    - [ ] Yes
    - [ ] No

32. Has your doctor told you that you are expecting more than 1 baby with this pregnancy (twins, triplets, etc.)?
    - [ ] Yes
    - [ ] No

33. Has your doctor ever told you that you have fetal growth restriction or uterine growth restriction with this pregnancy?
    - [ ] Yes
    - [ ] No

34. Have you ever delivered a baby who had a congenital birth defect like neural tube defect, cleft palate, or lip?
    - [ ] Yes
    - [ ] No

35. Are you currently breastfeeding?
    - [ ] Yes
    - [ ] No

36. Have you been hospitalized because of nausea and vomiting during this pregnancy?
    - [ ] Yes
    - [ ] No

37. Are you taking a vitamin/mineral supplement (like prenatal vitamins) or an herbal supplement?
    - [ ] Yes
    - [ ] No

   Does the supplement contain at least 150 mcg of iodine?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

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Oklahoma State Department of Health
WIC Service

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

39. 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

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

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

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

Fruits
   □ Apples
   □ Bananas
   □ Oranges
   □ Pears
   □ Grapefruit
   □ Melon
   □ Grapes
   □ Peaches
   □ Berries
   □ Plums
   □ 100% Fruit juice

Milk and Other Dairy Products
   □ Fat-free (skim) milk
   □ Cheese
   □ Low-fat (1/2 – 1)% milk
   □ Yogurt
   □ Reduced-fat (2%) milk
   □ Cottage cheese
   □ Whole milk
   □ Ice cream
   □ Unfortified or imitation milk
   □ Flavored milk

Meat and Meat Alternatives
   □ Beef/hamburger
   □ Sausage
   □ Pork
   □ Peanut butter/nuts
   □ Chicken
   □ Eggs
   □ Turkey
   □ Dry beans/peas
   □ Fish
   □ Tofu
   □ Cold cuts (hot dogs lunch meat)

41. 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
   □ 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)—chronic or pregnancy induced, 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, 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__________________________

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