

WIC Nutrition/Health Assessment

Pregnant Woman

Date _____

(Health Goal: Deliver a healthy, full-term infant, and be as healthy as possible.)

Name _____

Date of birth _____

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 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
If yes, when, and what type? _____
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 4-7
 1-3 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 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. Have you ever been pregnant before?
 Yes No
If yes, how many times? _____
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

Name _____

Date of birth _____

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
- 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 (1/2-1%) 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)

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 _____