

# WIC Nutrition/Health Assessment – Pregnant Woman

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Please complete the following questions to help WIC staff better understand your needs.

1. Which foods/beverages below do you usually eat or drink?

<b>Breads &amp; Grains:</b> <input type="checkbox"/> Bread <input type="checkbox"/> Rolls <input type="checkbox"/> Tortillas I also eat: _____	<input type="checkbox"/> Noodles <input type="checkbox"/> Pasta <input type="checkbox"/> Cereal <input type="checkbox"/> Rice <input type="checkbox"/> Crackers	<b>Vegetables &amp; Fruits:</b> <input type="checkbox"/> Broccoli <input type="checkbox"/> Green beans <input type="checkbox"/> Tomatoes I also eat: _____	<input type="checkbox"/> Potatoes <input type="checkbox"/> Corn/Peas <input type="checkbox"/> Apples <input type="checkbox"/> Bananas <input type="checkbox"/> Oranges <input type="checkbox"/> Berries
<b>Meats &amp; Protein:</b> <input type="checkbox"/> Hamburger <input type="checkbox"/> Chicken <input type="checkbox"/> Fish I also eat: _____	<input type="checkbox"/> Lunch meat <input type="checkbox"/> Tofu <input type="checkbox"/> Beans <input type="checkbox"/> Sausage <input type="checkbox"/> Peanut butter <input type="checkbox"/> Pork	<b>Milk &amp; Dairy:</b> <input type="checkbox"/> Cow's milk <input type="checkbox"/> Soy milk I also eat & drink: _____	<input type="checkbox"/> Lactose free milk <input type="checkbox"/> Cottage cheese <input type="checkbox"/> Yogurt <input type="checkbox"/> Cheese
<b>Other Beverages:</b> <input type="checkbox"/> Soft drinks <input type="checkbox"/> Juice I also drink: _____	<input type="checkbox"/> Sweet tea <input type="checkbox"/> Coffee <input type="checkbox"/> Unsweet tea <input type="checkbox"/> Energy drinks	<b>Other Foods:</b> <input type="checkbox"/> Doughnuts <input type="checkbox"/> Cake I also eat: _____	<input type="checkbox"/> Butter/Margarine <input type="checkbox"/> Cookies <input type="checkbox"/> Gravy <input type="checkbox"/> Chips

2. Do you eat any of the following?

- ☐ Raw or undercooked meat, fish, poultry, eggs
- ☐ Raw sprouts like alfalfa or bean sprouts
- ☐ Unheated lunch meats, hot dogs, processed meats
- ☐ Soft cheeses like Brie, Feta, Queso Fresco
- ☐ Raw or unpasteurized milk or juice
- ☐ I do not eat any of these foods

3. Are you on a special diet or a diet to lose weight?

- ☐ Yes ☐ No

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

5. Have you ever had bariatric surgery?

- ☐ Yes ☐ No

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

7. How many glasses of water do you drink daily? \_\_\_\_

8. How often are you physically active? \_\_\_\_X per wk

9. Do you take daily prenatal vitamins? ☐ Yes ☐ No  
If yes, do you take as instructed?

- ☐ Yes ☐ No ☐ Unsure

Are you taking a supplement with iron?

- ☐ Yes ☐ No ☐ Unsure

Are you taking a supplement with iodine?

- ☐ Yes ☐ No ☐ Unsure

Do you take herbal or botanical supplements?

- ☐ Yes ☐ No

21. What health issues do you have? \_\_\_\_\_

22. If you could wish for one healthy habit for yourself in this pregnancy, what would it be?  
\_\_\_\_\_

10. Do you eat/crave non-food items like clay, paint chips, dirt, or ice? ☐ Yes ☐ No

11. Do you feel you have enough food to feed your family? ☐ Yes ☐ No

12. Has your doctor said you have fetal growth restriction with this pregnancy? ☐ Yes ☐ No

13. Have you been hospitalized because of nausea and vomiting during this pregnancy? ☐ Yes ☐ No

14. Has a doctor said you have gestational diabetes with this pregnancy or with any pregnancy? ☐ Yes ☐ No

15. Has a doctor ever said you had preeclampsia in a previous pregnancy? ☐ Yes ☐ No

16. Have you ever delivered a baby who had a congenital birth defect like neural tube defect, cleft palate, or cleft lip? ☐ Yes ☐ No

17. Have you ever given birth to a baby weighing 5 pounds 8 ounces or less at birth? ☐ Yes ☐ No

18. Have you ever delivered a baby who weighed 9 pounds or more at birth? ☐ Yes ☐ No

19. Have you ever given birth to a baby born early? ☐ Yes \_\_\_\_\_ wks ☐ No

20. Have you had 2 or more miscarriages, or death of a fetus > 20 weeks (stillborn), or delivered a baby who died within 28 days of birth? ☐ Yes ☐ No

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

Below are suggested questions to facilitate WIC discussion.

- How are you feeling today? (*Assess appetite, nausea/vomiting, skipping meals [concern about adequate calories & nutrients]*)
- What are your mealtimes like? (*Assess environment [TV, phones, tablets at table], family meals, timing of meals, pattern [3 meals/2-3 snack], intake changes, intolerances, any special dietary needs, food preparation [who prepares, fast food/wk]*)
- What would you like to change about your eating? Activity level?
- Is there anything you would like to eat more or less of?
- Do you ever have a hard time chewing or eating certain foods? (*tooth loss, impaired ability to eat, oral health*)
- What have you heard about breastfeeding? (*Interest, support system, concerns, myths*)
- What has been helpful at this visit?

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