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

This institution is an equal opportunity provider.

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 (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)

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 _____