POSTPARTUM WOMEN NUTRITION QUESTIONS

Your Name:	Your Age:	Date:

Please check or write your answers to the following questions:

1. What Health Insurance do you have? ❑ Medi-Cal ❑ Private Insurance ❑ Other: ___________ ❑ None
2. When is your 6 week postpartum check-up or next doctor's appointment? ______________________________
3. What health conditions do you have?
   ❑ Diabetes ❑ High blood pressure ❑ Depression or other mental health problems
   ❑ Other: ____________________________ ❑ None
4. Did you have Gestational Diabetes with your last pregnancy? ❑ Yes ❑ No ❑ I don't know
5. Which of these do you take?
   ❑ Prenatal vitamins ❑ Multivitamin with folic acid ❑ Iron pills ❑ Other vitamins/minerals
   ❑ Laxatives ❑ Over the counter medications (Tylenol, Aspirin, etc) ❑ Herbs
   ❑ Home remedies (list)__________ ❑ Other medications________________ ❑ None
6. How do you feel about your current weight? ❑ I want to gain weight ❑OK ❑ I want to lose weight
7. In a typical week, how many days do you do moderate or vigorous physical activity (exercise) for 30 minutes or more? (For example: walking, jogging, dancing, swimming, bicycling, aerobics, soccer)
   Circle one: 1 day 2 days 3 days 4 days 5 days 6 days 7 days ❑ None
8. In the past 12 months, how many times did you see a dentist? ❑ None ❑ Once (1 visit) ❑ 2 or more visits
9. How often do you run out of money or food stamps (or EBT) to buy food?
   ❑ Often ❑ Sometimes ❑ Never
10. How many people do you have near you that you can ask for help in times of difficulty, such as watch your children or pets, give rides to the doctor or store, or help when you are sick? _________________________
11. Over the past <u>two weeks</u>, how often were you bothered by having little interest or pleasure in doing things?
    ❑ Not at all ❑ Several days ❑ More than half the days ❑ Nearly every day
12. Over the past <u>two weeks</u>, how often were you bothered by feeling down, depressed, or hopeless?
    ❑ Not at all ❑ Several days ❑ More than half the days ❑ Nearly every day
13. Which do you use? ❑ Cigarettes ❑ Alcohol ❑ Marijuana ❑ Other:___________ ❑ None

Please turn over →

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Date: ___________________________________ WIC Staff Name:____

WIC I.D. #: ______________________________ Height _____________ Weight __________ Pronto: Y N

Hgb/Hct in ISIS YES: Date: No: Referral given

14. Are you currently pregnant? ❑ Yes ❑ No ❑ I don't know

15. When do you plan to get pregnant again? ❑ Never ❑ in 0-6 months ❑ in 7-12 months ❑ in 1-2 years ❑ in 2 or more years

16. Are you currently using birth control: ❑ Yes ❑ No ❑ I had a tubal ligation

If YES, which method(s) of birth control are you using right now?

❑ None	❑ Birth Control Pill	❑ IUD	❑ Diaphragm/Cap/Sponge
❑ Abstinence	❑ Condom	❑ Depo Provera	❑ Cervical/Nuva Ring
❑ Calendar/Rhythm	❑ Spermicide (foam/gel)	❑ Withdrawal	❑ Other: ______________

17. Do you use Family PACT services (Green Health Access Programs card)? ❑ Yes ❑No ❑ I don't know

18. How many times a day do you eat? ______________________Meals ______________________Snacks

19. Are you on a special diet? ❑ Yes ❑ No If Yes, explain ________________________________

20. Are there foods you limit or do not eat? ❑ Yes ❑ No If Yes, which ones? ____________________

21. What do you eat/drink often? (Circle all that apply)

- ♦ Water Coffee Tea Regular Soda Diet Soda Gatorade
- ♦ Juice Punch or Kool Aid Alcohol Beer Wine
- ♦ Fruits Vegetables
- ♦ Milk: Non-Fat, 1%, 2%, Whole, Low-Lactose Soy Milk Other Milk

  Cheese Yogurt Cottage Cheese Pudding or Custard Tofu
- ♦ Meat Chicken Turkey Fish Hotdogs Nuts Beans or Lentils Eggs Peanut Butter
- ♦ Bread Cereals Tortillas Rice Noodles Pizza Rolls Crackers
- ♦ Candy Cookies Cake Donuts Ice Cream Chips French Fries Pan Dulce
- ♦ Others (list) ____

22. What nutrition and health questions would you like to discuss with your WIC counselor today?

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Circle Chart

Family Planning

Healthy Weight