BREASTFEEDING / POSTPARTUM WOMEN NUTRITION QUESTIONS

Mom's Name:	WIC ID:	Date:
		Mom's Age:

MY HEALTH & HEALTH CARE

How are you feeding your baby? ❑ Breastfeeding ❑ Formula ❑ Both

If you are breastfeeding, how is breastfeeding going for you? (Circle one)
(not good)**1** . . . . . **2** . . . . . **3** . . .. **4** . . . . . .**5** (great)

What type of health insurance do you have for yourself?
❑ No Health Insurance ❑ Medi-Cal ❑ AIM ❑ Private Insurance ❑ Other: _____

When is your 6 week postpartum check-up appointment? _____

What health conditions do you have?
❑ Diabetes ❑ High blood pressure ❑ Depression or other mental health problems
❑ Other: _____ ❑ None

Besides your 6 week postpartum check up, when is your next **medical** appointment? _____

In the past 12 months, how many times did you see a dentist? ❑ None ❑ Once (1 visit)
❑ 2 or more visits

In a typical week, how many days do you do moderate or vigorous physical activity (exercise) for 20 minutes or more? (For example: jogging, soccer, swimming, walking, dancing, bicycling, aerobics)
Circle one: 1 day 2 days 3 days 4 days 5 days 6 days 7 days ❑ None

Which of these do you take?
❑ Prenatal Vitamins ❑ Iron Pills ❑ Other Vitamins/Minerals ❑ Herbs
❑ Laxatives ❑ Over the counter Medications (Tylenol, Aspirin, etc) ❑ Birth Control
❑ Home Remedies (list)_____ ❑ Other medications_____ ❑ None

How do you feel about your weight now? ❑ I want to gain weight ❑OK ❑ I want to lose weight

NUTRITION

How many times a day do you eat? _____Meals _____Snacks

Are you on a special diet? ❑ Yes ❑ No If yes, explain _____

Are there foods you limit or do not eat? ❑ Yes ❑ No If yes, which ones? _____

What do you eat/drink on most days?
- ♦ Water Coffee Tea Regular Soda Diet Soda Gatorade Soy Milk
- ♦ Juice Punch or Kool Aid Alcohol Beer Wine
- ♦ Fruits Vegetables
- ♦ Milk (Non-Fat, Low-Fat, Whole) Cheese Yogurt Cottage Cheese Pudding or Custard
- ♦ Meat Chicken Turkey Fish Hotdogs Tofu Beans or Lentils Peanut Butter Eggs Nuts
- ♦ Bread Cereals Tortillas Rice Noodles Rolls Crackers Pan Dulce
- ♦ Candy Cookies Cake Donuts Ice cream Chips French Fries
- ♦ Others (list) _____

FAMILY PLANNING

Are you currently pregnant? ❑ **YES** ❑ **NO** ❑ **DON'T KNOW**

If pregnant, did you plan to be pregnant right now? ❑ **YES** ❑ **NO**
What is your due date? _____

If NOT pregnant, how many more children do you hope to have? _____

When do you plan to get pregnant again? ❑ Never ❑ in 0-6 months ❑ in 7-12 months
❑ in 13-24 months ❑ in 2 or more years

Are you currently using birth control?

❑ If YES, what method(s) are you using? _____
❑ If NO, what is your plan? _____ Where would you go for family planning services? _____

Do you use Family PACT services? ❑ Yes ❑No

Please turn over →

SMOKING AND ALCOHOL

How many cigarettes do you smoke a day? ❑ None ❑ 1-10 ❑ 11-20 ❑ more than 20

Does anyone in your household smoke? ❑ YES ❑ NO

How often do you drink alcoholic beverages?
❑ Every day ❑ Every week ❑ 2-3 times a month ❑ Rarely ❑ Never

When you drink alcohol, how many drinks do you usually have in one occasion?
0 1 2 3 4 5 or more

Which of the following recreational drugs do you use?
❑ Marijuana ❑ Meth ❑ Cocaine ❑ Heroine ❑ Ecstasy ❑ None ❑ Other:_____

HOME ENVIRONMENT

How many people do you have near you that you can ask for help in times of difficulty, such as watch over children or pets, give rides to the hospital or store, or help when you are sick?
❑ 0 ❑ 1 ❑ 2-5 ❑ 6-9 ❑ 10 or more

During the past month, how often did you feel sad or depressed?
❑ Never/Rarely ❑ Some of the time ❑ Often times ❑ Most of the time

During the past month, how often did you feel lonely?
❑ Never/Rarely ❑ Some of the time ❑ Often times ❑ Most of the time

During the past month, how often did you have crying spells?
❑ Never/Rarely ❑ Some of the time ❑ Often times ❑ Most of the time

During the past month, how often did you lose interest in most things you usually enjoyed (hobbies, work, etc.)?
❑ Never/Rarely ❑ Some of the time ❑ Often times ❑ Most of the time

OTHER

How often do you run out of money or food stamps to buy food?
❑ Often ❑ Sometimes ❑ Never

Does anyone in your family participate in the Commodity Supplemental Food Program (boxes of food)?
❑ Yes ❑ No ❑ I don't know

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

_____

_____

FOR STAFF ONLY

Date: _____ WIC Staff Name:_____

Height _____ Weight _____ Staff Initials _____

Hgb/Hct in ISIS _____ _____YES: Date:_____ _____ No: Referral given

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