PHFE-WIC Program

PRENATAL NUTRITION QUESTIONS

Name:	Age:

Please circle or write your answers to the following questions:

1. How many weeks pregnant are you?____________________
2. How many weeks pregnant were you when you first found out that you were pregnant?____________
3. When is your next doctor's appointment?____________________
4. What concerns does your doctor have about your pregnancy?
   Weight Gain　Weight Loss　What I Eat　High Blood Sugar　High Blood Pressure
   Low Iron in Blood　None　I don't know　Other ____________________
5. Have you had a screening test for HIV/AIDS?　Yes　No
6. Which of these do you take?　Prenatal Vitamins　Iron Pills　Herbs　Other Vitamins or Minerals
   Laxatives　Over the Counter Medications (Tylenol, Aspirin, etc…)　None
   Other Medications____________Home Remedies (list)____________
7. Which of these conditions do you have?
   Nausea　Vomiting　Heartburn　Constipation　Swelling　None　Other (list) __________
8. What do you think about your weight gain with this pregnancy?　Not enough　OK　Too Much

9. How many times a day do you eat?　__________Meals　__________Snacks
10. How many times a week do you eat fast food or food from a restaurant?
    1-2 times　3-4 times　5 or more times　Never
11. What do you eat or drink on most days?
    - Water　Coffee　Tea　Regular Soda　Diet Soda　Gatorade
    - Juice　Punch or Kool Aid　Alcohol　Beer　Wine
    - Fruit　Vegetables
    - Milk: Non-fat, 1%, 2%, Whole, Low-Lactose　Soy Milk　Yogurt　Tofu
      Cottage Cheese　Pudding or Custard　Cheese
    - Meat　Chicken　Turkey　Fish　Hotdogs　Beans or Lentils　Peanut Butter　Eggs　Nuts
    - Breads　Cereals　Tortillas　Rice　Noodles　Rolls　Crackers　Pan Dulce
    - Candy　Cookies　Cakes　Donuts　Ice Cream　Chips　French Fries
      Other (list) ______________________________
12. What things, other than food do you crave to eat?　Dirt　Clay　Ice　Laundry Starch
    Cigarette Butts　Paint Chips　Other (list) ____________　None
13. Are you on a special diet?　Yes　No　If yes, explain____________________

Please turn over →

For Staff Use Only: Date: ____________ WIC Staff Name:____________

WIC ID#____________Height____________Weight ____________

Hgb/Hct in ISIS:　______YES: Date of Blood Test______　_____NO: Referral Given, HOLD Placed, Comments Documented

14. Are there foods you limit or do not eat? Yes No If yes, what foods?___________________
15. How would you describe your eating habits now? Great Good OK Not so good

16. Have you ever breastfed? Yes No If yes, for how long?___________________
17. What do you think about breastfeeding your new baby?
    I'm not interested I'm thinking about it I want to I will definitely

18. During the time you were pregnant but didn't yet know you were pregnant, how many alcoholic drinks did you usually have at one time?
    10 or more 9 8 7 6 5 4 3 2 1 0 drinks
19. During the time you were pregnant but didn't yet know you were pregnant, how often did you drink beer, wine or other alcoholic beverages? Every day Almost every day 3-4 days a week 1-2 days a week 2-3 days a month Once a month Less than once a month Never
20. Within the last month, how many times have you had 3 or more alcoholic beverages at one time?
    10 or more 9 8 7 6 5 4 3 2 1 0 times
21. Currently, when you drink alcohol, how many drinks do you usually have at one time?
    10 or more 9 8 7 6 5 4 3 2 1 0 drinks
22. Currently, how often do you drink alcoholic beverages?
    Every day Almost every day 3-4 days a week 1-2 days a week
    2-3 days a month Once a month Less than once a month Never
23. What kind of physical activity do you do on most days? Walk Run Bike Dance Sports Swim Exercise class/Gym Garden None Other (list) ___________________
24. How often do you run out of money or food stamps to buy food? Often Sometimes Never
25. Does anyone in your family participate in the Commodity Supplemental Food Program (boxes of food)?
    Yes No I don't know
26. What nutrition and health questions would you like to discuss with your WIC counselor today?___________
    ____