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		100	<b>沙安宁教师</b>		<b>经验证的</b>	<b>7.74 2.4 3.5 3.5</b>	<b>企业</b> 有特别		455 637	5 4 4 5 1	2010/1900	<b>全种的人类。</b> 最后每年	423	Things are
21.2	A COLUMN	2.1.20	1.4				100		<b>"一大大大"</b>	<b>"我",在"</b> "	SAME TO SE	1 网络红色红色	Some This garden	TO VALUE OF THE PARTY OF THE PA
A X	72 - 10 C	100			84. A. C.	With the second	<b>不是一种的人的</b>	<b>经过的存在的</b>	de la company				Part Care	A Property of the same of the
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## Ohio Department of Health • Bureau of Nutrition Services WIC Health History for Breastfeeding Women and Postpartum Women

Name	-			Today's date	Age
Date this pregnancy ended	What was your	due date?		Your weight at delivery	Your weight before pregnance
			(49)	,	(11
Check one		· · · · · ·			
☐ live birtho		stillbirth	☐ miscarriag	e 🗆 abortion	☐ infant death (22, 45, 49
Number of past pregnancies	How many end	ed in live birth?		Date previous pregnancy	ended
(39)			(42)		(43
Prenatal doctor or clinic				Date of last doctor visit	
If you are currently breastfeeding, fill ou	ut <b>Sections 1</b> a	nd <b>2.</b> If you	are <b>not</b> curre	ently breastfeeding fi	ll out Section 2.
Section 1					
My baby breastfeeds	· <u>-</u>				
everyhours ortimes a	a day and	times a nig	ght Ho	ow long on each side?_	(70
If your baby gets bottles			<u></u>		
What is in the bottle?			Ho	ow often?	
Do you have problems with					
☐ Let down ☐ Hot, hard breasts	☐ Latch	☐ Pain	in your breas	ts     Sore nipples	
☐ Other				☐ No problems	(74
How long do you want to breastfeed your baby?					
Are you going back to work or school?	·				
☐ Yes When?		□ No			
What kind of support for breastfeeding do you h					
Triactiona of support for Breastreeding do you in	ave at nome:				
   Would you like more breastfeeding help?					
Yes □ No					
			<del></del>		
Castian 2					
Section 2  Did you ever breastfeed your baby?				· · · · · · · · · · · · · · · · · · ·	
	□ No				
Why did you stop?			Но	w old was your baby v	then you stonned?
Did you have a C-section?					men you stopped:
☐ Yes ☐ No					(93
List any problems you have had.					
With this pregnancy					
With past pregnancies					None (44)
Check any health problems you currently have.					
· · · · · · · · · · · · · · · · · · ·		☐ High blood	d pressure	☐ Lactose intolera	nce
Other		<del></del>			e (91, 93, 94
List any medicines you take. `					· · · · · · · · · · · · · · · · · · ·
					(93)
HEA 4449 2/08					OVER 🖝

Has the doctor tested your blood for lead?					· ·
☐ Yes Results		□ Do	n't know		(21)
Have you ever had a baby with a birth weight of nine por	unds or more?				
☐ Yes ☐ No					(22, 49)
Was your baby born three or more weeks early?					
☐ Yes How many weeks?					(49)
Was your baby born with any health problems?					
☐ Yes ☐ No					
If yes, explain					(23)
Check all supplements you take.	<del></del> -	<del></del>			
☐ Prenatal vitamins/vitamins ☐ Iron	☐ Herbs	□ Ca	lcium		
☐ Other				☐ None	(30)
Are you on a special diet?				<del></del>	
☐ Yes, your choice ☐ Yes, from your docto	or 🗆 No				(30, 35, 91, 93)
List your food allergies			<u> </u>	<del></del>	
				☐ None	(93)
Check any of these non-food items that you eat or crave	 ).			<del></del>	
☐ Paint chips ☐ Ice ☐ Printed	paper 🔲 Dirt/c	:lay 🔲	Starch	☐ Coffee grounds	
☐ Other	•	-		□ None	(30)
Check all that apply.	<del></del>				
☐ Someone else shops for food. ☐ Lu	isually shop for foc	od $\square$	Lusually do n	ot eat at home.	
	isually cook.		-	ter, motel, or temporary pla	ace
☐ I have a working stove or microwave and refr	•		THE HI G SHC	ter, moter, or temporary pie	ice.
☐ I run out of money or food stamps to buy foo	- ,	. —			(66, 95)
What do you think about your eating habits?					
Name one or two things you do for physical activity or ex	ercise.		·		
, , , , , , , , , , , , , , , , , , , ,					
How many cigarettes, pipes, cigars do/did you smoke?			<del></del>		<del></del>
Now	a dav	a week	☐ None		
Last three months of this pregnancy	<del>-</del>	a week	☐ None		
Three months before this pregnancy	a day a day	a week	☐ None		(46)
If anyone living in your home smokes, where do they smo	_ ,				(46)
		-l			
	☐ No one smo	okes			(46)
Check all alcoholic beverages you drink.	<b>—</b>				
☐ Wine ☐ Beer ☐ Coolers	Liquor				
Now	•	a week	☐ None		
Last three months of this pregnancy	a day	a week	☐ None		
Three months before this pregnancy	a day	a week	☐ None		(47, 66)
Check all drugs you currently use.				·	
☐ Marijuana ☐ Crack ☐ Speed	☐ LSD	☐ Heroin			
☐ Crystal meth ☐ Inhalants ☐ Prescript	ion drugs (misuse)				
☐ Other				☐ None	(48, 66, 93)
During the last six months, have you been physically, sexu	ally or verbally abuse	d2			
☐ Yes ☐ No	any or verbany abaset	u:	•		(57)
Do you have any questions or concerns?				<del></del>	(67)
y any quadratic of concerno.					
			<del></del>		