Location of CPA	HT	WT	BMI	HGB

Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Pregnant Women

Name			Today's date	Age (39,40)
Your due date is	Weight before pregnancy (12,13)	Number of past pregnancies (39)	Number of live births (45)	Date last pregnancy ended (43)
Prenatal doctor or clinic			How far along were you at your first doctor visit for this pregnancy? (16)	

If this is not your first pregnancy, fill out **Sections 1** and **2.** Fill out **Section 2** if this is your first pregnancy.

Section 1

Are you breastfeeding now?
☐ Yes ☐ No (69)

Have you ever breastfed?
☐ Yes ☐ No
If yes, why did you stop?_____ How old was your baby when you stopped? _____

Have you had any problems with past pregnancies?
☐ Yes ☐ No (44,45)
If yes, list _____

Check if you ever had a baby with one of these birth weights.
☐ 5 pounds and 8 ounces or less ☐ 9 pounds or more ☐ Neither (22, 49)

Have you ever had a baby born three or more weeks early?
☐ Yes How many weeks? _____ ☐ No (49)

Have you ever had a baby born with any health problems?
☐ Yes ☐ No (23)
If yes, explain_____

Section 2

Check any problems you are having with this pregnancy.
☐ Heartburn ☐ Poor appetite ☐ Vomiting ☐ Diarrhea ☐ Nausea ☐ Constipation
☐ Other _____ ☐ None (44)

Check any of your health problems.
☐ Diabetes ☐ Depression ☐ Dental ☐ High blood pressure ☐ Lactose Intolerance
☐ Other _____ ☐ None (44, 91, 93, 94)

Have you lost weight during this pregnancy?
☐ Yes How much? _____ ☐ No (10)

List any medicines you take.
☐ None (93)

Check all supplements you take.
☐ Prenatal vitamins ☐ Vitamins ☐ Iron ☐ Herbs ☐ Calcium ☐ Folic acid
☐ Other _____ ☐ None (30)

OVER ☛

Has the doctor tested your blood for lead?

☐ Yes Results _____ ☐ No ☐ Don't know (21)

Are you on a special diet?

☐ Yes, your choice ☐ Yes, from your doctor ☐ No (30, 35, 91, 93)

List your food allergies

☐ None (93)

Check any of these non-food items that you **eat** or **crave.**

☐ Paint chips ☐ Ice ☐ Printed paper ☐ Dirt/clay ☐ Starch ☐ Coffee grounds

☐ Other _____ ☐ None (30)

Check all that apply.

☐ Someone else shops for food. ☐ I usually shop for food. ☐ I usually do not eat at home.

☐ Someone else does the cooking. ☐ I usually cook. ☐ I live in a shelter, motel, or temporary place.

☐ I have a working stove or microwave and refrigerator in my home.

☐ I run out of money or food stamps to buy food. (66, 95)

What do you think about your eating habits?

Name one or two things you do for physical activity or exercise.

How many cigarettes, pipes, cigars do/did you smoke?

Now	_____a day	_____a week	☐ None
Anytime during this pregnancy	_____a day	_____a week	☐ None
Three months before this pregnancy	_____a day	_____a week	☐ None

(46)

If anyone living in your home smokes, where do they smoke?

☐ Inside ☐ Outside ☐ Car ☐ No one smokes (46)

Check all alcoholic beverages you drink.

☐ Wine ☐ Beer ☐ Coolers ☐ Liquor

Now	_____a day	_____a week	☐ None
Anytime during this pregnancy	_____a day	_____a week	☐ None
Three months before this pregnancy	_____a day	_____a week	☐ None

(47, 66)

Check all drugs you used at any time during this pregnancy.

☐ Marijuana ☐ Crack ☐ Speed ☐ LSD ☐ Heroin

☐ Crystal meth ☐ Inhalants ☐ Prescription drugs (misuse)

☐ Other _____ ☐ None (48, 66, 93)

During the last six months, have you been physically, sexually or verbally abused?

☐ Yes ☐ No (48, 66, 93)

Do you have any questions or concerns?

_____