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?_____
_____

For Staff Use Only

Circle Chart