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| **Health – Pregnancy Information** |
| 1. **\*How many times have you been pregnant?**
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **\*How many Births? (*if applicable*)**
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **\*Date last pregnancy ended (month, year) (*if applicable*)**
 | \_\_\_\_\_\_\_ month \_\_\_\_\_\_\_\_ year |
| 1. **\*Do you currently have diabetes?**

**If Yes,**  | 🞏 Yes 🞏 No🞏 Gestational 🞏 Diabetes (Type 1 / Type 2) |
| 1. **\*Do you currently have high blood pressure?**
 | 🞏 Yes 🞏 No |
| 1. **\*Do you have any current health or medical conditions? If Yes, select all that apply: (*See Ref 13*)**
 | 🞏 Yes 🞏 No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **\*Tell me about any health or medical conditions with your past pregnancies? (*if applicable*)**
 | 🞏 Gestational Diabetes 🞏 Pregnancy-induced hypertension/Preeclampsia 🞏 History of preterm delivery >32 but <39 weeks 🞏 2 or more pregnancy losses🞏 Stillborn or death before 1 month of age 🞏 Baby born 5 lbs 8 oz or less 🞏 Baby born 9 lbs or more 🞏 Baby born with a birth defect🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏 None of these |
| 1. **\*Do you have any problems with your teeth or gums?**
 | 🞏 Yes 🞏 No |
| 1. **\*Have you been seen by a dentist in the last 6 months??**
 | 🞏 Yes 🞏 No |

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| **Health – Additional Information** |
| ***WIC provides referrals. Your answers to these questions are kept confidential and will not affect your eligibility.******These questions are asked so WIC can help you and your baby.******The following questions pertain to your pregnancy, including the months that you may not have known you were pregnant*** |
| 1. **\*Have you smoked cigarettes, e-cigarettes, or a vape pen?**
 | 🞏 Yes 🞏 No |
| 1. **\*Have you used marijuana, including edibles and lotions/oils?**
 | 🞏 Yes 🞏 No |
| 1. **\*Does anyone smoke tobacco or marijuana inside your home or car?**
 | 🞏 Yes 🞏 No |
| 1. **\*Have you had any drinks of beer, liquor, or wine?**
 | 🞏 Yes 🞏 No |
| 1. **\*Have you used any drugs?**
 | 🞏 Yes 🞏 No |
| 1. **\*In the past 6 months, has your partner or anyone in your household threatened or physically hurt you in any way?**
 | 🞏 Yes 🞏 No |
| 1. **\*During the past 2 weeks, how often have you felt down, depressed, or hopeless?**
 | 🞏 Not at all🞏 Several days🞏 More than half the days🞏 Nearly every day |
| 1. **\*During the past 2 weeks, how often have you had little interest or little pleasure in doing things that you usually enjoy?**
 | 🞏 Not at all🞏 Several Days🞏 More than half the days🞏 Nearly every day |
| 1. **\*Within the past 12 months you worried whether your food would run out before you got money to buy more.**
 | 🞏 Often true🞏 Sometimes true🞏 Never true🞏 Don’t know or Refused |
| 1. **\*Within the past 12 months the food you bought just didn’t last and you didn’t have money to get more.**
 | 🞏 Often true🞏 Sometimes true🞏 Never true🞏 Don’t know or Refused |
| 1. **\*Are you worried that you may not have housing in the next 2 months?**
 | 🞏 Yes 🞏 No |
| ***WIC is required to ask the following three questions. Responses are optional. Your answers are kept confidential,******are for data collection purposes only, and will not affect your eligibility. You may change your responses at any time. (Ask at Initial Certification)*** |
| 1. ***\*What sex was listed on your original birth certificate?***
 | 🞏 Female🞏 Male🞏 Unknown🞏 Choose not to disclose |
| 1. ***\*What is your current gender identity?***
 | 🞏 Female🞏 Male🞏 Female-to-Male (FTM)/Transgender Male/Trans Man🞏 Male-to-Female (MTF)/Transgender Female/Trans Woman🞏 Genderqueer, neither exclusively male nor female🞏 Additional gender category or other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏 Choose not to disclose |
| 1. ***\*How do you identify your sexual orientation?***
 | 🞏 Straight or heterosexual🞏 Lesbian, gay or homosexual🞏 Bisexual🞏 Something else, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏 Do not know🞏 Choose not to disclose |

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| **Nutrition** |
| 1. **\*Which of the following best describes how you are eating?**
 | 🞏 Good🞏 Not eating enough (poor appetite / too tired to prepare food)🞏 Eating too much🞏 Not making healthy choices |
| 1. **\*Are you currently experiencing any of the following?**
 |  |
| *select all that apply:*🞏 Nausea🞏 Vomiting🞏 Heartburn🞏 Constipation | 🞏 Diarrhea🞏 Leg cramps🞏 Swelling🞏 None of these |
| 1. **\*Do you have any food allergies?**
 | 🞏 Yes 🞏 No |
| *If yes, select all that apply:*🞏 Milk🞏 Soy🞏 Eggs🞏 Nuts🞏 Peanuts | 🞏 Shellfish🞏 Fish🞏 Wheat🞏 Corn🞏 Other (Enter Note) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **\*Do you follow a special diet or limit certain foods?**
 | 🞏 Yes 🞏 No |
| *If yes, select all that apply:*🞏 Diabetic🞏 Increased Calorie🞏 Decreased Calorie🞏 Low Lactose | 🞏 Gluten Free 🞏 Low carb/High Protein🞏 Vegan🞏 Vegetarian🞏 Post-bariatric surgery🞏 Other (Enter Note) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **\*How often do you eat from the following food groups?**
 |
| 1. Fruit
 | 🞏 Most days | 🞏 Some days | 🞏 Rarely/never |
| 1. Vegetables
 | 🞏 Most days | 🞏 Some days | 🞏 Rarely/never |
| 1. Whole Grains
 | 🞏 Most days | 🞏 Some days | 🞏 Rarely/never |
| 1. Milk / Dairy Foods
 | 🞏 Most days | 🞏 Some days | 🞏 Rarely/never |
| 1. Protein Foods
 | 🞏 Most days | 🞏 Some days | 🞏 Rarely/never |
| 1. Desserts / Sweets
 | 🞏 Most days | 🞏 Some days | 🞏 Rarely/never |
| 1. Junk Foods
 | 🞏 Most days | 🞏 Some days | 🞏 Rarely/never |
| 1. **\*Do you eat any of the following?**
 |
| 🞏 Cold deli meat🞏 Cold hot dogs🞏 Unpasteurized cheese (queso fresco/brie)🞏 Sushi | 🞏 Unpasteurized or raw milk🞏 Rare or uncooked meat/eggs🞏 None of the above |
| 1. **\*Do you eat any non-food items? (dirt, ice, laundry starch, cornstarch, clay or paint chips**
 | 🞏 Yes 🞏 No |
| 1. **\*What do you drink on most days?**
 |
| 🞏 Water 🞏 Cow’s Milk Type of Milk: 🞏 whole 🞏 2% 🞏 1% 🞏 nonfat🞏 Soy🞏 Non-dairy Beverage (Rice, Nut, etc.)🞏 100% Juice | 🞏 Coffee/Tea🞏 Soda🞏 Other Caffeinated/Energy Drinks🞏 Other Sugar Sweetened Drinks🞏 Other (Enter Note) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **\*Do you take any prenatal vitamins?**
 | 🞏 No🞏 Daily🞏 Sometimes |
| 1. **\*Do you take any herbs, other vitamin/mineral supplements or home remedies?**
 | 🞏 Yes 🞏 No |