Location of CPA	HT	WT	BMI	HGB

Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Breastfeeding Women and Postpartum Women

Name	Today's date	Age (39, 40)

Date this pregnancy ended	What was your due date? (49)	Your weight at delivery	Your weight before pregnancy (11)

Check one

☐ live birth _____pounds _____ounces ☐ stillbirth ☐ miscarriage ☐ abortion ☐ infant death (22, 45, 49)

Number of past pregnancies (39)	How many ended in live birth? (42)	Date previous pregnancy ended (43)

Prenatal doctor or clinic	Date of last doctor visit

If you are currently breastfeeding, fill out **Sections 1** and **2**. If you are **not** currently breastfeeding fill out **Section 2**.

Section 1

My baby breastfeeds

every _____hours or _____times a day and _____times a night How long on each side?_____ (70)

If your baby gets bottles

What is in the bottle? _____ How often? _____

Do you have problems with

☐ Let down ☐ Hot, hard breasts ☐ Latch ☐ Pain in your breasts ☐ 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 have at home?

Would you like more breastfeeding help?

☐ Yes ☐ No

Section 2

Did you ever breastfeed your baby?

☐ Still breastfeeding ☐ Yes ☐ No

Why did you stop? _____ How old was your baby when you stopped? _____

Did you have a C-section?

☐ Yes ☐ No (93)

List any problems you have had.

With this pregnancy _____

With past pregnancies _____ ☐ None (44)

Check any health problems you currently have.

☐ Diabetes ☐ Depression ☐ Dental ☐ High blood pressure ☐ Lactose intolerance

☐ Other _____ ☐ None (91, 93, 94)

List any medicines you take.

(93)

Has the doctor tested your blood for lead?
☐ Yes Results _____ ☐ No ☐ Don't know (21)

Have you ever had a baby with a birth weight of nine pounds or more?
☐ Yes ☐ No (22, 49)

Was your baby born three or more weeks early?
☐ Yes How many weeks? _____ ☐ No (49)

Was your baby born with any health problems?
☐ Yes ☐ No
If yes, explain _____ (23)

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

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
Last three months of 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
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 ☐ Prescription drugs (misuse)
☐ Other _____ ☐ None (48, 66, 93)

During the last six months, have you been physically, sexually or verbally abused?
☐ Yes ☐ No (67)

Do you have any questions or concerns?
_____