

WIC Nutrition/Health Assessment - Pregnant Woman

Name: _____ Date of Birth: _____ Today's Date: _____

1. Do you take daily prenatal vitamins?
☐ Yes ☐ No
If yes, do you take as directed?
☐ Yes ☐ No ☐ Unsure
Does your supplement contain iron?
☐ Yes ☐ No ☐ Unsure
Does your supplement contain iodine?
☐ Yes ☐ No ☐ Unsure
Do you take herbal or botanical supplements?
☐ Yes ☐ No
2. Do you eat any of the following?
☐ Raw or undercooked meat, fish, poultry, eggs
☐ Raw sprouts like alfalfa or bean sprouts
☐ Unheated: lunch meats, hot dogs, processed meats
☐ Unpasteurized soft cheeses like Brie, Feta, Queso Fresco
☐ Raw or unpasteurized milk or juice
☐ Unwashed fruits and vegetables
☐ Deli Salads
3. Do you eat/crave non-food items like clay, paint chips, dirt, or ice?
☐ Yes ☐ No
4. Do you have a hard time chewing or eating certain foods?
☐ Yes ☐ No
5. Do you feel you have enough food to feed your family?
☐ Yes ☐ No
6. Are you on a special diet or a diet to lose weight?
☐ Yes ☐ No
7. Have you used starvation, diet pills, laxatives, or vomiting as a method to lose weight in the past 12 months?
☐ Yes ☐ No
8. Have you ever had weight loss surgery?
☐ Yes ☐ No
9. During THIS pregnancy, were you:
☐ Diagnosed with fetal growth restriction
☐ Diagnosed with gestational diabetes
☐ Hospitalized because of nausea and vomiting
10. In ANY pregnancy, were/did you:
☐ Diagnosed with gestational diabetes
☐ Diagnosed with preeclampsia
☐ Deliver a baby who had a congenital birth defect like neural tube defect, cleft palate, or cleft lip
☐ Deliver a baby who weighed 9 pounds or more at birth
☐ Deliver a baby born 38 weeks gestation or earlier
11. Have you had 2 or more miscarriages, or death of a fetus $\geq$ 20 weeks (stillborn), or delivered a baby who died within 28 days of birth?
☐ Yes ☐ No
12. What health issues do you have, if any?

13. What would you like to discuss or learn more about today?
☐ Healthy eating
☐ Physical activity
☐ Breastfeeding
☐ Weight management
☐ Mental health resources or referrals
☐ Other: _____

For Staff Use Only

- What are your mealtimes like? What would you like to change about your eating? What do you want to eat more or less of? What have you heard about breastfeeding?

This institution is an equal opportunity provider.