|  |  |
| --- | --- |
| **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 |

|  |  |
| --- | --- |
| **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 |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 | |