

**Ohio Department of Health • Bureau of Nutrition Services**  
**WIC Health History for Pregnant Women**

Name			Today's date		Age (39,40)
Your due date is	Weight before pregnancy (12,13)	Number of past pregnancies (39)	Number of live births (45)	Date last pregnancy ended (43)	
Prenatal doctor or clinic			How far along were you at your first doctor visit for this pregnancy? (16)		

If this is not your first pregnancy, fill out **Sections 1 and 2**. Fill out **Section 2** if this is your first pregnancy.

### Section 1

Are you breastfeeding now? <input type="checkbox"/> Yes <input type="checkbox"/> No (69)
Have you ever breastfed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, why did you stop? _____ How old was your baby when you stopped? _____
Have you had any problems with past pregnancies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list _____ (44,45)
Check if you ever had a baby with one of these birth weights. <input type="checkbox"/> 5 pounds and 8 ounces or less <input type="checkbox"/> 9 pounds or more <input type="checkbox"/> Neither (22, 49)
Have you ever had a baby born three or more weeks early? <input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No (49)
Have you ever had a baby born with any health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain _____ (23)

### Section 2

Check any problems you are having with this pregnancy. <input type="checkbox"/> Heartburn <input type="checkbox"/> Poor appetite <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Other _____ <input type="checkbox"/> None (44)
Check any of your health problems. <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Dental <input type="checkbox"/> High blood pressure <input type="checkbox"/> Lactose Intolerance <input type="checkbox"/> Other _____ <input type="checkbox"/> None (44, 91, 93, 94)
Have you lost weight during this pregnancy? <input type="checkbox"/> Yes How much? _____ <input type="checkbox"/> No (10)
List any medicines you take. <input type="checkbox"/> None (93)
Check all supplements you take. <input type="checkbox"/> Prenatal vitamins <input type="checkbox"/> Vitamins <input type="checkbox"/> Iron <input type="checkbox"/> Herbs <input type="checkbox"/> Calcium <input type="checkbox"/> Folic acid <input type="checkbox"/> Other _____ <input type="checkbox"/> None (30)

Has the doctor tested your blood for lead? <input type="checkbox"/> Yes Results _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know (21)
Are you on a special diet? <input type="checkbox"/> Yes, your choice <input type="checkbox"/> Yes, from your doctor <input type="checkbox"/> No (30, 35, 91, 93)
List your food allergies <input type="checkbox"/> None (93)
Check any of these non-food items that you <b>eat</b> or <b>crave</b> . <input type="checkbox"/> Paint chips <input type="checkbox"/> Ice <input type="checkbox"/> Printed paper <input type="checkbox"/> Dirt/clay <input type="checkbox"/> Starch <input type="checkbox"/> Coffee grounds <input type="checkbox"/> Other _____ <input type="checkbox"/> None (30)
Check all that apply. <input type="checkbox"/> Someone else shops for food. <input type="checkbox"/> I usually shop for food. <input type="checkbox"/> I usually do not eat at home. <input type="checkbox"/> Someone else does the cooking. <input type="checkbox"/> I usually cook. <input type="checkbox"/> I live in a shelter, motel, or temporary place. <input type="checkbox"/> I have a working stove or microwave and refrigerator in my home. <input type="checkbox"/> 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 <input type="checkbox"/> None Anytime during this pregnancy _____ a day _____ a week <input type="checkbox"/> None Three months before this pregnancy _____ a day _____ a week <input type="checkbox"/> None (46)
If anyone living in your home smokes, where do they smoke? <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Car <input type="checkbox"/> No one smokes (46)
Check all alcoholic beverages you drink. <input type="checkbox"/> Wine <input type="checkbox"/> Beer <input type="checkbox"/> Coolers <input type="checkbox"/> Liquor Now _____ a day _____ a week <input type="checkbox"/> None Anytime during this pregnancy _____ a day _____ a week <input type="checkbox"/> None Three months before this pregnancy _____ a day _____ a week <input type="checkbox"/> None (47, 66)
Check all drugs you used at any time during this pregnancy. <input type="checkbox"/> Marijuana <input type="checkbox"/> Crack <input type="checkbox"/> Speed <input type="checkbox"/> LSD <input type="checkbox"/> Heroin <input type="checkbox"/> Crystal meth <input type="checkbox"/> Inhalants <input type="checkbox"/> Prescription drugs (misuse) <input type="checkbox"/> Other _____ <input type="checkbox"/> None (48, 66, 93)
During the last six months, have you been physically, sexually or verbally abused? <input type="checkbox"/> Yes <input type="checkbox"/> No (67)
Do you have any questions or concerns? _____