

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 <input type="checkbox"/> live birth _____pounds _____ounces <input type="checkbox"/> stillbirth <input type="checkbox"/> miscarriage <input type="checkbox"/> abortion <input type="checkbox"/> 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 <input type="checkbox"/> Let down <input type="checkbox"/> Hot, hard breasts <input type="checkbox"/> Latch <input type="checkbox"/> Pain in your breasts <input type="checkbox"/> Sore nipples <input type="checkbox"/> Other _____ <input type="checkbox"/> No problems (74)
How long do you want to breastfeed your baby?
Are you going back to work or school? <input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No
What kind of support for breastfeeding do you have at home?
Would you like more breastfeeding help? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 2

Did you ever breastfeed your baby? <input type="checkbox"/> Still breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No Why did you stop? _____ How old was your baby when you stopped? _____
Did you have a C-section? <input type="checkbox"/> Yes <input type="checkbox"/> No (93)
List any problems you have had. With this pregnancy _____ With past pregnancies _____ <input type="checkbox"/> None (44)
Check any health problems you currently have. <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 (91, 93, 94)
List any medicines you take. (93)

Has the doctor tested your blood for lead? <input type="checkbox"/> Yes Results _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know	(21)
Have you ever had a baby with a birth weight of nine pounds or more? <input type="checkbox"/> Yes <input type="checkbox"/> No	(22, 49)
Was your baby born three or more weeks early? <input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No	(49)
Was your baby born with any health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain _____	(23)
Check all supplements you take. <input type="checkbox"/> Prenatal vitamins/vitamins <input type="checkbox"/> Iron <input type="checkbox"/> Herbs <input type="checkbox"/> Calcium <input type="checkbox"/> Other _____ <input type="checkbox"/> None	(30)
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 eat or crave . <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 Last three months of 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 Last three months of 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 currently use. <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? _____	