Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Breastfeeding Women and Postpartum Women

<table>
<thead>
<tr>
<th>Name</th>
<th>Today's date</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Date this pregnancy ended</th>
<th>What was your due date?</th>
<th>Your weight at delivery</th>
<th>Your weight before pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(49)</td>
<td>(11)</td>
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</table>

<table>
<thead>
<tr>
<th>Check one</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ live birth</td>
<td>pounds</td>
<td>ounces</td>
<td>仍然birth</td>
</tr>
<tr>
<td>□ stillbirth</td>
<td></td>
<td></td>
<td>miscarriage</td>
</tr>
<tr>
<td>□ miscarriage</td>
<td></td>
<td></td>
<td>abortion</td>
</tr>
<tr>
<td>□ abortion</td>
<td></td>
<td></td>
<td>infant death</td>
</tr>
<tr>
<td>□ infant death</td>
<td></td>
<td></td>
<td>(22, 45, 49)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of past pregnancies</th>
<th>How many ended in live birth?</th>
<th>Date previous pregnancy ended</th>
</tr>
</thead>
<tbody>
<tr>
<td>(39)</td>
<td>(42)</td>
<td>(43)</td>
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<table>
<thead>
<tr>
<th>Prenatal doctor or clinic</th>
<th>Date of last doctor visit</th>
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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?__________

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

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

List any problems you have had.
With this pregnancy ____________________________________________ □ None (44)
With past pregnancies ____________________________________________

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.

HEA 4449 2/08
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?