

Complete frontside ONLY

Maternal Health Assessment

Date(s): _____ Name: _____ Age: _____

Maternal Health History Questions *(please complete all questions on this side – leave the backside blank)*

Where do you go for prenatal/postpartum care? Doctor/clinic name: _____

Check all pregnancy and delivery related conditions you have or had in the past:

- Gestational diabetes High blood pressure Pregnancy loss Early baby (less than 39 weeks)
 Small baby (5 pounds 8 ounces, or less) Large baby (9 pounds or more) Baby born with a health problem
 Other: _____ N/A

Do you have any medical conditions, illness, food allergies, or a recent surgery or injury? Please describe: _____ N/A

Please list medications or herbs you take: _____ N/A

Do you or your dentist have any dental concerns? Yes _____ No I don't have a dentist

Has anyone in your family been tested for lead? Yes (levels): _____ No I don't know

Have you been/are you being treated for depression or other mental health concerns? Yes No

Over the past two weeks, how often have you been bothered by any of the following problems?

• Little interest or pleasure in doing things:

- Not at all Several days More than half the days Nearly every day

• Feeling down, depressed, or hopeless:

- Not at all Several days More than half the days Nearly every day

Do you live in a temporary place (shelter, hotel, etc.)? Yes No

Have you been physically, verbally, sexually abused, or neglected? Yes No

Are there times when anyone makes you feel unsafe? Yes No

Do you have a safe place to go? Yes No

Do you worry about running out of food? Yes No

Do you use local food banks/pantries? Yes No

What questions or concerns do you have about your health, eating habits, and breastfeeding? _____

This portion is to be completed by WIC staff

New Cert (date): _____ Recert (date): _____ HA (date): _____ Continue Goal

Location of WIC Program Application: _____

HT _____ WT _____ Hgb _____ (optional)

Nutrition, Breastfeeding, and Physical Activity Questions (to be completed by WIC staff member)

What does screen time look like for you? Time/day _____ Days/week _____

Tell me about the physical activities you enjoy: _____ Time/day _____ Days/week _____

Briefly describe what you eat and drink each day:

Targeted diet assessment may include:

- Vitamins, iron sources, enhancers, inhibitors
- Dairy/calcium/vitamin D
- Iodine/folic acid
- Whole grains/fiber
- Protein sources
- Fruits and vegetables
- Sugar sweetened drinks/foods
- Foods limited/refused/avoided
- Unsafe foods (including non-food items)
- Meals away from home/fast food
- Working kitchen appliances
- Religious or cultural diets
- Water source

Caregiver with limited feeding decision/inability to prepare foods:

Current/history of alcohol or substance abuse Mental illness, including severe depression
 Intellectual disability Physical disability Age ≤ 17 years N/A

(P) What do you know about breastfeeding or giving breast milk to your baby?

(P) Breastfeeding intention: Yes No Maybe

(B) Tell me about your experience offering breast milk to your baby so far:

Targeted breastfeeding assessment may include:

- Knowledge of appropriate feeding frequency and amount
- Latch difficulties
- Engorgement
- Pain or discomfort of breasts and/or nipples
- Pump needs/questions
- Referrals or follow ups needed

(B) What is your goal for breastfeeding or giving breastmilk to your baby?

Notes: