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>
<td></td>
<td></td>
<td>(39, 49)</td>
</tr>
</tbody>
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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>
</tr>
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<table>
<thead>
<tr>
<th>Check one</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ live birth pounds ounces ☐ stillbirth ☐ miscarriage ☐ abortion ☐ infant death</td>
</tr>
<tr>
<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>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prenatal doctor or clinic</th>
<th>Date of last doctor visit</th>
</tr>
</thead>
</table>

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

(74)

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

(93)

List any problems you have had.

- With this pregnancy _ _
- With past pregnancies _ _
- ☐ None

(44)

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.

(93)

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 (93)

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, 65)

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 (57)

Do you have any questions or concerns?