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

<table>
<thead>
<tr>
<th>Name</th>
<th>Today's date</th>
<th>Age (39,40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your due date is</td>
<td>Weight before pregnancy</td>
<td>Number of past pregnancies</td>
</tr>
<tr>
<td></td>
<td>(12,13)</td>
<td>(39)</td>
</tr>
<tr>
<td>Number of live births</td>
<td>Date last pregnancy ended</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(45)</td>
<td>(48)</td>
</tr>
<tr>
<td>Prenatal doctor or clinic</td>
<td>How far along were you at your first doctor visit for this pregnancy?</td>
<td></td>
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<tr>
<td></td>
<td>(16)</td>
<td></td>
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</tbody>
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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?**
- [ ] Yes
- [ ] No

**Have you ever breastfed?**
- [ ] Yes
- [ ] No

If yes, why did you stop?

**How old was your baby when you stopped?**

**Have you had any problems with past pregnancies?**
- [ ] Yes
- [ ] No

If yes, list

**Check if you ever had a baby with one of these birth weights.**
- [ ] 5 pounds and 8 ounces or less
- [ ] 9 pounds or more
- [ ] Neither

**Have you ever had a baby born three or more weeks early?**
- [ ] Yes
- [ ] How many weeks? ___________
- [ ] No

**Have you ever had a baby born with any health problems?**
- [ ] Yes
- [ ] No

If yes, explain

**Section 2**

**Check any problems you are having with this pregnancy.**
- [ ] Heartburn
- [ ] Poor appetite
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Nausea
- [ ] Constipation
- [ ] Other

**Check any of your health problems.**
- [ ] Diabetes
- [ ] Depression
- [ ] Dental
- [ ] High blood pressure
- [ ] Lactose Intolerance
- [ ] Other

**Have you lost weight during this pregnancy?**
- [ ] Yes
- [ ] How much? ___________
- [ ] No

**List any medicines you take.**
- [ ] None

**Check all supplements you take.**
- [ ] Prenatal vitamins
- [ ] Vitamins
- [ ] Iron
- [ ] Herbs
- [ ] Calcium
- [ ] Folic acid
- [ ] Other

HEA 4455 2/08
Has the doctor tested your blood for lead?
☐ Yes  Results ________________________ ☐ No  ☐ Don’t know

Are you on a special diet?
☐ Yes, your choice ☐ Yes, from your doctor  ☐ No

List your food allergies
☐ None

Check any of these non-food items that you eat or crave.
☐ Paint chips  ☐ Ice  ☐ Printed paper  ☐ Dirt/clay  ☐ Starch  ☐ Coffee grounds
☐ Other ________________________  ☐ None

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.

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

Anytime during this pregnancy    ________________________ a day  ________________________ a week  ☐ None

Three months before this pregnancy    ________________________ a day  ________________________ a week  ☐ None

If anyone living in your home smokes, where do they smoke?
☐ Inside  ☐ Outside  ☐ Car  ☐ No one smokes

Check all alcoholic beverages you drink.
☐ Wine  ☐ Beer  ☐ Coolers  ☐ Liquor

Now    ________________________ a day  ________________________ a week  ☐ None

Anytime during this pregnancy    ________________________ a day  ________________________ a week  ☐ None

Three months before this pregnancy    ________________________ a day  ________________________ a week  ☐ None

Check all drugs you used at any time during this pregnancy.
☐ Marijuana  ☐ Crack  ☐ Speed  ☐ LSD  ☐ Heroin
☐ Crystal meth  ☐ Inhalants  ☐ Prescription drugs (misuse)
☐ Other ________________________  ☐ None

During the last six months, have you been physically, sexually or verbally abused?
☐ Yes  ☐ No

Do you have any questions or concerns?