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>Date this pregnancy ended</td>
<td>What was your due date?</td>
<td>Your weight at delivery</td>
</tr>
<tr>
<td>Check one</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ live birth _______pounds _______ounces</td>
<td>☐ stillbirth</td>
<td>☐ miscarriage</td>
</tr>
<tr>
<td>Number of past pregnancies</td>
<td>How many ended in live birth?</td>
<td>Date previous pregnancy ended</td>
</tr>
<tr>
<td>Prenatal doctor or clinic</td>
<td>Date of last doctor visit</td>
<td></td>
</tr>
</tbody>
</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

<table>
<thead>
<tr>
<th>every _______hours or _______times a day and _______times a night</th>
<th>How long on each side?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your baby gets bottles</td>
<td>What is in the bottle?</td>
</tr>
<tr>
<td>Do you have problems with</td>
<td>☐ Let down</td>
</tr>
<tr>
<td>☐ Other</td>
<td></td>
</tr>
</tbody>
</table>

How long do you want to breastfeed your baby?

<table>
<thead>
<tr>
<th>Yes</th>
<th>When?</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you going back to work or school?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Yes</td>
<td>When?</td>
<td>☐ No</td>
</tr>
<tr>
<td>What kind of support for breastfeeding do you have at home?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Would you like more breastfeeding help?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Section 2**

Did you ever breastfeed your baby?

<table>
<thead>
<tr>
<th>☐ Still breastfeeding</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why did you stop?</td>
<td></td>
<td>How old was your baby when you stopped?</td>
</tr>
</tbody>
</table>

Did you have a C-section?

<table>
<thead>
<tr>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
</table>

List any problems you have had.

With this pregnancy | | | ☐ None |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>With past pregnancies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check any health problems you currently have.

<table>
<thead>
<tr>
<th>☐ Diabetes</th>
<th>☐ Depression</th>
<th>☐ Dental</th>
<th>☐ High blood pressure</th>
<th>☐ Lactose intolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Other</td>
<td></td>
<td></td>
<td></td>
<td>☐ None</td>
</tr>
</tbody>
</table>

List any medicines you take.

| | |
| | |

OVER
Has the doctor tested your blood for lead?  
- Yes  
- Results  
- No  
- Don’t know  

Have you ever had a baby with a birth weight of nine pounds or more?  
- Yes  
- No  

Was your baby born three or more weeks early?  
- Yes  
- How many weeks?  
- No  

Was your baby born with any health problems?  
- Yes  
- No  

Check all supplements you take.  
- Prenatal vitamins/vitamins  
- Iron  
- Herbs  
- Calcium  
- Other  
- None  

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  
- Last three months of this pregnancy  
- Three months before this pregnancy  

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  

Check all drugs you currently use.  
- 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?