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>
<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>
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Check one
- [ ] live birth _____ pounds _____ ounces
- [ ] stillbirth
- [ ] miscarriage
- [ ] abortion
- [ ] infant death

Number of past pregnancies

[ ] How many ended in live birth?

Date previous pregnancy ended

[ ] Date of last doctor visit

Prenatal doctor or clinic

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

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.

OVER
Has the doctor tested your blood for lead?
- Yes
- 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
- No

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

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

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

Do you have any questions or concerns?