Postpartum Questionnaire

Name ____________________________        Date_______________________

Please answer these questions to help with your WIC visit today.

1. Does anyone smoke inside your home?        □ Yes □ No

2. What does your household use for drinking water?
   □ city/town/county water          □ well water          □ bottled water          □ other

3. Does the refrigerator in your home work?        □ Yes □ No

4. Does the stove in your home work?        □ Yes □ No

5. In the past month, have there been days when you did not have enough food or money to buy food?        □ Yes □ No

6. Have you seen your doctor since you had your baby?        □ Yes □ No

7. Were there any problems with your delivery?        □ Yes □ No
   If “yes”, list problem(s):

8. Have you been told by your doctor that you have any health problems?        □ Yes □ No
   If “yes”, list problem(s):

9. Since having your baby, what concerns do you have about your health?

10. Have you had any problems with your teeth or gums since you had your baby?        □ Yes □ No

11. Are you breastfeeding or pumping breast milk for your baby now?        □ Yes □ No
   If breastfeeding or pumping breast milk, how is it going?

12. Which of these do you take?
   □ multi-vitamins          □ iron supplement          □ folic acid supplement          □ medicine from doctor
   □ over-the-counter medicine (like pain relievers, antacids, laxatives)          □ herbal supplement
   □ other ____________________________          □ none

13. What type of birth control do you use? □ pills □ shots □ other □ none □ had tubes tied

14. Which of these do you do?
   □ smoke cigarettes          □ chew tobacco          □ drink alcohol          □ use drugs          □ none

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15. How do you feel about your weight since you had your baby?
☐ weigh too much ☐ don’t weigh enough ☐ it’s okay ☐ not sure

16. How does the amount of food you eat now compare with when you were pregnant?
☐ eat more ☐ about the same ☐ eat less ☐ not sure

17. How many times a day do you eat? This includes meals and snacks of all kinds.
☐ less than 3 ☐ 3-4 ☐ 5-6 ☐ more than 6 ☐ not sure

18. How many times a week do you eat meals and snacks away from home (or eat take-out meals)?
This includes vending machines, fast foods, delis and all types of restaurants.
☐ never or rarely ☐ 1-3 times a week ☐ 4-6 times a week ☐ more than 6 times a week ☐ not sure

19. Do you follow any kind of special diet?
☐ Yes ☐ No

20. Do you eat fruit everyday?
☐ Yes ☐ No

21. Do you eat vegetables everyday?
☐ Yes ☐ No

22. What kind of milk do you drink?
☐ skim or fat-free ☐ 1% low-fat ☐ 2% low-fat ☐ whole ☐ not sure ☐ none
☐ other ____________________________

23. Which of these do you drink everyday?
☐ milk ☐ water ☐ flavored water ☐ fruit juice ☐ fruit drinks or punch
☐ regular soda ☐ sweet tea ☐ sports drinks ☐ other ____________________________

24. Check any of the following items you eat:
☐ ashes ☐ baking soda ☐ carpet fibers ☐ chalk ☐ cigarette butts
☐ clay ☐ dirt ☐ ice ☐ matches ☐ paint chips
☐ starch (corn or laundry) ☐ other ____________________________ ☐ none

25. How does the amount of exercise you get now compare with when you were pregnant?
☐ exercise more ☐ about the same ☐ exercise less ☐ not sure

26. Do you watch more than 2 hours of TV everyday?
☐ Yes ☐ No

27. What would you like to talk to the nutritionist about today?

Thank you!