Prenatal 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 became pregnant?  □ Yes  □ No

7. Is this your first pregnancy?  □ Yes  □ No

8. Has your doctor said that you have any health problems?  □ Yes  □ No
   If "yes", list problem(s):

9. What concerns do you have about your health during this pregnancy?

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

11. Which of these do you have?  □ nausea  □ vomiting  □ heartburn  □ constipation  □ none

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

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

14. How do you feel about your weight change since you became pregnant?
   □ gaining too much  □ gaining too little  □ it's okay  □ not sure  □ weight has not changed

15. 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

 turn page over →
16. How does the amount of food you eat now compare with before you were pregnant?
   - a lot more
   - a little more
   - about the same
   - a little less
   - a lot less
   - not sure

17. 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

18. Do you follow any kind of special diet?
   - Yes
   - No

19. Do you eat fruit every day?
   - Yes
   - No

20. Do you eat vegetables every day?
   - Yes
   - No

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

22. Which of these do you drink everyday?
   - milk
   - water
   - flavored water
   - fruit juice
   - fruit drinks or punch
   - regular soda
   - sweet tea
   - sports drinks
   - other ___________________________

23. 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

24. Check any of the following foods you eat:
   - raw or unpasteurized milk
   - soft cheeses like feta, Brie, blue cheese or queso fresco or blanco
   - raw or undercooked meat or poultry, fish (including sushi), shellfish, eggs or tofu
   - hot dogs or cold cuts (deli or lunch meats) not reheated to steaming
   - none

25. How does the amount of exercise you get now compare with before you were pregnant?
   - a lot more
   - a little more
   - about the same
   - a little less
   - a lot less
   - not sure

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

27. Have you thought about how you will feed your baby (like breastfeed)?
   - Yes
   - No

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

Thank you!