

Postpartum Questionnaire

Name _____ Date _____

Age: _____ Date of Measurements: _____ Weight: _____

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

1. Does anyone in your household smoke? Yes No
If yes: Inside Outside
2. How many people live in your house? Adults: _____ Children: _____
3. What does your household use for drinking water?
 city/town/county water well water bottled water
 other _____
4. Does the refrigerator, stove and microwave 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? If yes: Would you be interested in receiving information on local food banks or government assistance agencies?
 Yes No Yes No
6. Does your household receive food stamps? Yes No
7. Were there any problems with your delivery? (C-section, Breech, Low fluids, etc.) If "yes", list problem(s): Yes No
8. Have you been told by your doctor that you have any health problems during your pregnancy (Diabetes, High Blood Pressure, Depression, Thyroid problems, etc)?
If "yes", list problem(s): Yes No
9. Since having your baby, do you have any concerns about your health? Yes No
10. What was your weight right before your baby was born?
11. Have you had any problems with your teeth or gums since you had your baby? Yes No
12. Are you breastfeeding or pumping breast milk for your baby now?
If breastfeeding or pumping breast milk, how is it going? Yes No
13. 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
14. What type of birth control do you use? pills shots other none had tubes tied
 Intra Uterine Device (IUD)
15. Which of these do you do?
 smoke cigarettes chew tobacco drink alcohol use drugs none

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16. How do you feel about your weight since you had your baby?
 weigh too much don't weigh enough it's okay not sure
-
17. How does the amount of food you eat now compare with when you were pregnant?
 eat more about the same eat less not sure
-
18. On most days, how many times do you eat?
Number of meals _____ number of snacks _____
-
19. How many times a week do you eat out at a restaurant or eat take-out?
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
-
20. Do you follow any kind of special diet? If yes what type? Yes No
-
21. Do you eat fruit everyday? Yes No
-
22. Do you eat vegetables everyday? Yes No
-
23. What kind of milk do you drink?
 skim or fat-free 1% low-fat 2% low-fat whole not sure none
 other _____
-
24. Which of these do you drink everyday?
 milk water flavored water fruit juice fruit drinks or punch
 regular soda sweet tea sports drinks other _____
-
25. 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
-
26. How does the amount of exercise you get now compare with when you were pregnant?
 exercise more about the same exercise less not sure
-
27. Do you watch more than 2 hours of TV ? Yes No
-
28. When you see the nutritionist today, what would you like to talk about?
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Thank you!