

Prenatal Questionnaire

Name _____ Date _____

Age _____ Height: _____

Date of Measurements _____ Weight: _____

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

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1. Does anyone in your household smoke? Yes No
If yes: Inside Outside
-
2. What does your household use for drinking water?
 city/town/county water well water bottled water other
-
3. Does the refrigerator, stove and microwave in your home work? Yes No
-
4. 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
-
5. Does your household receive food stamps? Yes No
-
6. How many people live in your house? Adults: _____ Children: _____
-
7. Has your doctor said that you have any health problems (Diabetes, High Blood Pressure, Depression, Thyroid problems, etc)? Yes No
If "yes", list problem(s): _____
-
8. What concerns do you have about your health during this pregnancy? _____
-
9. Have you had any problems with your teeth or gums since you became pregnant? Yes No
-
10. Which of these do you have? nausea vomiting heartburn constipation none
-
11. 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
-
12. Which of these do you do?
 smoke cigarettes chew tobacco drink alcohol use drugs none
-
13. On most days, how many times do you eat?
number of meals _____ number of snacks _____
-

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14. 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
-
15. 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
-
16. Do you follow any kind of special diet? If yes what type? Yes No
-
17. Do you eat fruit every day? Yes No
-
18. Do you eat vegetables every day? Yes No
-
19. What kind of milk do you drink?
 skim or fat-free 1% low-fat 2% low-fat whole not sure none
 other _____
-
20. Which of these do you drink everyday?
 milk water flavored water fruit juice fruit drinks or punch
 regular soda sweet tea sports drinks other _____
-
21. 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
-
22. 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
 hot dogs or cold cuts (deli or lunch meats) not reheated to steaming
 none
-
23. 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
-
24. Do you watch more than 2 hours of TV ? Yes No
-
25. How long do you plan to breastfeed your baby?
-
26. When you see the nutritionist today, what would you like to talk about?
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Thank you!