



# Breastfeeding/Postpartum Application

**WIC is here to help you eat well, be active and stay healthy during your child-bearing years. The information you share will guide us on how to best serve you.**

Name \_\_\_\_\_ Your Date of Birth 331, 332, 333 \_\_\_\_\_ Today's date \_\_\_\_\_

1. How many babies did you just have?  1  2  3 or more *List the number* \_\_\_\_\_ 335

2. Was your baby born 3 or more weeks early?  No  Yes, \_\_\_\_\_ weeks early 142

3. Baby(ies) birth date: \_\_\_\_\_ Baby(ies) birth weight(s): \_\_\_\_\_ 337, 141

Check if you had a  Baby died in first month or  Miscarriage (+20 weeks pregnancy) 321

## Feeding is a good way for you & your baby to get to know each other. How are you feeding your baby?

4.  Breastfeeding  Breastfeeding + Formula  Formula only\*

\* If formula only, did you ever breastfeed?  No  Yes → \_\_\_\_\_ days or \_\_\_\_\_ weeks 701

- I introduced formula at \_\_\_\_\_ weeks
- How many times a day (in 24 hours) are you breastfeeding? \_\_\_\_\_ times 601, 602
- How confident are you about breastfeeding your baby? (circle a number below)  
not confident 0 1 2 3 4 5 very confident
- How long would you like to breastfeed your baby? \_\_\_\_\_

5. If formula feeding: how much formula does your baby drink during 24 hours \_\_\_\_\_ oz

6. What concerns or questions do you have about feeding your baby?  
\_\_\_\_\_  
\_\_\_\_\_

7. Are you seeing a doctor or dietitian for any medical problems?  No  Yes 341-349; 351-362  
Describe: \_\_\_\_\_

8. In the last 3 months, have you been to the hospital for any reason (besides baby's birth)?  
 No  Yes →  Emergency room  Hospital overnight  Surgery 359  
If any, describe: \_\_\_\_\_

9. Do you see a dentist for regular check-ups?  No  Yes, Date of Last Visit: \_\_\_\_\_ 381

10. Check any problems you had during **this** pregnancy or delivery:  
 C-Section 359  Anemia 201  High blood pressure 345  Diabetes 303, 343  
 None apply  Other: \_\_\_\_\_

11. List any medication, vitamin, mineral, or herbal supplement you are taking: *list* \_\_\_\_\_  
\_\_\_\_\_ 427.1, 427.4

12. Would you like more information on birth control or family planning?  No  Yes

**Next Page** →

\*\*\*Office use only\*\*\*

Application reviewed by \_\_\_\_\_ Certification Date \_\_\_\_\_

Ht \_\_\_\_\_ Wt \_\_\_\_\_ Pre-PG wt \_\_\_\_\_ BMI \_\_\_\_\_ 101, 111, 133 Hgb /Hct \_\_\_\_\_ 201 Staff initials \_\_\_\_\_

**What you eat and drink can affect your and your baby's health. Tell us about your eating habits.**

13. I usually eat \_\_\_\_\_ meals/day and \_\_\_\_\_ snacks/day.
14. I make my own meals at home most of the time  No  Yes *Describe your meals*  
\_\_\_\_\_ 801, 802, 902
15. Other than juice, I eat fruit:  1 cup/day or less  2 cups/day  3 cups/day or more
16. I eat vegetables:  1 cup/day or less  2 cups/day  3 cups/day or more
17. I eat fast food:  1 time/week or less  2-4 times/week  5 times/week or more
18. I run out of money or Food Stamps to buy food.  No  Yes  Sometimes
19. Are you on a special diet?  No  Yes, Describe: \_\_\_\_\_ 427.2
20. Do you ever eat non-food items, like dirt, clay, soap, ice or freezer frost, cigarette butts?  
 No  Yes, Describe: \_\_\_\_\_ 427.3
21. Do you have trouble eating any foods?  No  Yes, List: \_\_\_\_\_ 354, 355
22. Do you have any food allergies?  No  Yes, List: \_\_\_\_\_ 353
23. Do you fast, binge or vomit to control your weight?  No  Yes  Not now, in the past
24. How active are you? (circle one) not very active 0 1 2 3 4 5 very active
25. What activities do you and/or your family do for fun? \_\_\_\_\_  
\_\_\_\_\_
26. Since your new baby was born, how often have you felt down, depressed, or hopeless?  
 Never  Rarely  Sometimes  Often  Always
27. What concerns do you have about your weight or diet? \_\_\_\_\_  
\_\_\_\_\_

**Avoiding tobacco, alcohol and illegal drugs will help keep you & your family healthy. Please tell us more these habits.**

27. Does anyone in your house smoke?  No  Yes
28. Do you smoke now?  No  Yes → how many cigarettes a day? \_\_\_\_\_ 371  
• Has your smoking:  Continued  Increased  Decreased  Stopped  Tried to stop
29. Do you drink alcohol now?  No  Yes how many drinks a day? \_\_\_ days a week? \_\_\_\_ 372
30. Mark any drugs you are using now:  Marijuana  Methadone  
 Cocaine  Crank  Crack  Methamphetamine  
 Speed  Heroin  Other \_\_\_\_\_ 372  
 None  None now, but in the past. *how long ago?*  
\_\_\_\_\_
31. Are you in a relationship with anyone who has pushed, hit or threatened you in any way?  
 No  Yes  Sometimes 901

**What are your main concerns today – and how can WIC help?**

\_\_\_\_\_

Thank you! Were you on WIC during your pregnancy at our clinic?  No  Yes  
If yes → you do not need to answer the questions on the following page.  
No → Please answer additional questions about your pregnancy (next page)

**Additional questions for Post-Partum & Breastfeeding applicants.**

**Complete only if not on WIC at this clinic during your most recent pregnancy.**

Name \_\_\_\_\_

Your Date of Birth \_\_\_\_\_

Today's Date \_\_\_\_\_

1. How many times have you been pregnant, including this pregnancy? \_\_\_\_\_ times

Ages of your children: \_\_\_\_\_

2. Check any of the following problems you had with **any** pregnancies (*check all that apply*):

- Never pregnant before
- Baby born 3 or more weeks early <sup>311</sup>
- Had no problems with my pregnancies
- Small baby, less than 5 pounds 8 oz. at birth <sup>312</sup>
- Miscarriage – how many \_\_\_\_\_ <sup>321</sup>
- Large baby, more than 9 pounds at birth <sup>337</sup>
- Stillbirth – how many \_\_\_\_\_ <sup>321</sup>
- Genetic or birth defect <sup>339</sup>
- Abortions – how many \_\_\_\_\_
- Baby died before 1 month old <sup>321</sup>
- Other \_\_\_\_\_

**Avoiding tobacco, alcohol and illegal drugs will help keep you & your family healthy.  
Please tell us more about these habits.**

3. In the 3 months before getting pregnant this time:

- Did you drink alcohol?  No  Yes <sup>372</sup>
- If yes, on average, how many drinks a day? \_\_\_\_\_ How many days a week? \_\_\_\_\_ <sup>372</sup>
- Did you smoke?  No  Yes If yes, how many cigarettes a day? \_\_\_\_\_ <sup>371</sup>

4. **During this pregnancy:**

- Did you drink alcohol?  No  Yes \_\_\_\_\_ drinks a day \_\_\_\_\_ days a week <sup>372</sup>
- Did you smoke?  No  Yes \_\_\_\_\_ cigarettes a day <sup>371</sup>
- Mark any of these drugs you used:  None during pregnancy, but in the past <sup>372</sup>
  - Marijuana  Cocaine  Heroin  Methamphetamine
  - Crack  Speed  Methadone  Crank
  - Other \_\_\_\_\_  None of these substances

5. Did you have any medical conditions or problems during your most *recent* pregnancy?

No  Yes → please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you.*