### Ohio Department of Health • Bureau of Nutrition Services

**WIC Health History for Breastfeeding Women and Postpartum Women**

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
<th>Age (18, 49)</th>
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**Date this pregnancy ended** | **What was your due date?** | **Your weight at delivery** | **Your weight before pregnancy** |
| (39) | (49) | (11) | (22, 45, 49) |

**Check one**
- [] live birth
- [] pounds
- [] curces
- [] stillbirth
- [] miscarriage
- [] abortion
- [] infant death

**Number of past pregnancies** | **How many ended in live birth?** | **Date previous pregnancy ended** | **Date last doctor visit** |
| (39) | (42) | (43) | (48) |

**Prenatal doctor or clinic**

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If you are currently breastfeeding, fill out Sections 1 and 2. If you are not currently breastfeeding fill out Section 2.

### Section 1

**My baby breastfeeding**

- [ ] every __________ hours or _________ times a day and _________ times a night
- [ ] How long on each side? (70)

**If your baby gets bottles**

- [ ] What is in the bottle?
- [ ] How often? 

**Do you have problems with**

- [] Let down
- [] Hot, hard breasts
- [] Latch
- [] Pain in your breasts
- [] Sore nipples
- [] Other
- [] No problems (74)

**How long do you want to breastfeed your baby?**

Are you going back to work or school?

- [] Yes
- [] When? __________
- [] No

What kind of support for breastfeeding do you have at home?

**Would you like more breastfeeding help?**

- [] Yes
- [] No

### Section 2

**Did you ever breastfeed your baby?**

- [ ] Still breastfeeding
- [ ] Yes
- [ ] No

**Why did you stop?**

- [ ] How old was your baby when you stopped? 

**Did you have a C-section?**

- [ ] Yes
- [ ] No (93)

**List any problems you have had:**

- [ ] With this pregnancy
- [ ] With past pregnancies

**Check any health problems you currently have:**

- [] Diabetes
- [] Depression
- [] Dental
- [] High blood pressure
- [] Lactose intolerance
- [] Other

**List any medicines you take.**

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Has the doctor tested your blood for lead?
- Yes
- No
- Don’t know

Have you ever had a baby with a birth weight of nine pounds or more?
- Yes
- No

Were your baby born three or more weeks early?
- Yes
- No

Were your baby born with any health problems?
- Yes
- No

If yes, explain:

Check all supplements you take.
- Prenatal vitamins/vitamins
- Iron
- Herbs
- Calcium
- Other

Check any of these non-food items that you eat or crave.
- Paint chips
- Ice
- Printed paper
- Dirt/clay
- Starch
- Coffee grounds
- Other

Check all that apply.
- Someone else shops for food.
- I usually shop for food.
- I usually do not eat at home.
- Someone else does the cooking.
- I usually cook.
- I live in a shelter, motel, or temporary place.
- I have a working stove or microwave and refrigerator in my home.
- I run out of money or food stamps to buy food.

What do you think about your eating habits?

Name one or two things you do for physical activity or exercise:

How many cigarettes, pipes, cigars do/did you smoke?
- Now
- Last three months of this pregnancy
- Three months before this pregnancy

If anyone living in your home smokes, where do they smoke?
- Inside
- Outside
- Car
- No one smokes

Check all alcoholic beverages you drink.
- Wine
- Beer
- Coolers
- Liquor

Check all drugs you currently use.
- Marijuana
- Crack
- Speed
- LSD
- Heroin
- Crystal meth
- Inhalants
- Prescription drugs (misuse)
- Other

During the last six months, have you been physically, sexually or verbally abused?
- Yes
- No

Do you have any questions or concerns?