Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Pregnant Women

If this is not your first pregnancy, fill out Sections 1 and 2. Fill out Section 2 if this is your first pregnancy.

Section 1

Are you breastfeeding now?

☐ Yes  ☐ No

Have you ever breastfed?

☐ Yes  ☐ No

If yes, why did you stop?

How old was your baby when you stopped?

Have you had any problems with past pregnancies?

☐ Yes  ☐ No

If yes, list

Check if you ever had a baby with one of these birth weights:

☐ 5 pounds and 8 ounces or less  ☐ 9 pounds or more  ☐ Neither

Have you ever had a baby born three or more weeks early?

☐ Yes  How many weeks?  ☐ No

Have you ever had a baby born with any health problems?

☐ Yes  ☐ No

If yes, explain

Section 2

Check any problems you are having with this pregnancy.

☐ Heartburn  ☐ Poor appetite  ☐ Vomiting  ☐ Diarrhea  ☐ Nausea  ☐ Constipation  ☐ Other

Check any of your health problems:

☐ Diabetes  ☐ Depression  ☐ Dental  ☐ High blood pressure  ☐ Lactose Intolerance  ☐ Other

Have you lost weight during this pregnancy?

☐ Yes  How much?  ☐ No

List any medications you take:

☐ None

Check all supplements you take:

☐ Prenatal vitamins  ☐ Vitamins  ☐ Iron  ☐ Herbs  ☐ Calcium  ☐ Folic acid  ☐ Other

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Has the doctor tested your blood for lead?
- [ ] Yes  
- [ ] Results ____________________________  
- [ ] No  
- [ ] Don't know  

Are you on a special diet?
- [ ] Yes, your choice  
- [ ] Yes, from your doctor  
- [ ] No  

List your food allergies  
- [ ] None  

Check any of these non-food items that you eat or crave.
- [ ] Paint chips  
- [ ] Ice  
- [ ] Printed paper  
- [ ] Dirt/clay  
- [ ] Starch  
- [ ] Coffee grounds  
- [ ] Other: ____________________________  
- [ ] None  

Check all that apply.
- [ ] Someone else shops for food.  
- [ ] I usually shop for food.  
- [ ] 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 did you smoke?

Now ______ a day  ______ a week  
Anytime during this pregnancy ______ a day  ______ a week  
Three months before this pregnancy ______ a day  ______ a week  

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  

Now ______ a day  ______ a week  
Anytime during this pregnancy ______ a day  ______ a week  
Three months before this pregnancy ______ a day  ______ a week  

Check all drugs you used at any time during this pregnancy.
- [ ] Marijuana  
- [ ] Crack  
- [ ] Speed  
- [ ] LSD  
- [ ] Heroin  
- [ ] Crystal meth  
- [ ] Inhalants  
- [ ] Prescription drugs (misuse)  
- [ ] Other: ____________________________  
- [ ] None  

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

Do you have any questions or concerns?

___________________________________________