Postpartum Questionnaire

Name _____ Date_____

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

1. Does anyone smoke inside your home? ❒ Yes ❒ No

2. What does your household use for drinking water?
   ❒ city/town/county water ❒ well water ❒ bottled water ❒ other

3. Does the refrigerator in your home work? ❒ Yes ❒ No

4. Does the stove 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? ❒ Yes ❒ No

6. Have you seen your doctor since you had your baby? ❒ Yes ❒ No

7. Were there any problems with your delivery? ❒ Yes ❒ No
   If "yes", list problem(s):

8. Have you been told by your doctor that you have any health problems? ❒ Yes ❒ No
   If "yes", list problem(s):

9. Since having your baby, what concerns do you have about your health?

10. Have you had any problems with your teeth or gums since you had your baby? ❒ Yes ❒ No

11. Are you breastfeeding or pumping breast milk for your baby now? ❒ Yes ❒ No
    If breastfeeding or pumping breast milk, how is it going?

12. 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

13. What type of birth control do you use? ❒ pills ❒ shots ❒ other ❒ none ❒ had tubes tied

14. Which of these do you do?
    ❒ smoke cigarettes ❒ chew tobacco ❒ drink alcohol ❒ use drugs ❒ none

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15. How do you feel about your weight since you had your baby?
❒ weigh too much ❒ don't weigh enough ❒ it's okay ❒ not sure

16. How does the amount of food you eat <u>now</u> compare with when you were pregnant?
❒ eat more ❒ about the same ❒ eat less ❒ not sure

17. How many times a day do you eat? This includes meals and snacks of all kinds.
❒less than 3 ❒ 3-4 ❒ 5-6 ❒ more than 6 ❒ not sure

18. How many times a week do you eat meals and snacks away from home (or eat take-out meals)? 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

19. Do you follow any kind of special diet? ❒ Yes ❒ No

20. Do you eat fruit everyday? ❒ Yes ❒ No

21. Do you eat vegetables everyday? ❒ Yes ❒ No

22. What kind of milk do you drink?
❒ skim or fat-free ❒ 1% low-fat ❒ 2% low-fat ❒ whole ❒ not sure ❒ none
❒ other _____

23. Which of these do you drink everyday?
❒ milk ❒water ❒ flavored water ❒fruit juice ❒ fruit drinks or punch
❒ regular soda ❒ sweet tea ❒ sports drinks ❒ other_____

24. 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

25. How does the amount of exercise you get <u>now</u> compare with when you were pregnant?
❒ exercise more ❒ about the same ❒ exercise less ❒ not sure

26. Do you watch more than 2 hours of TV everyday? ❒ Yes ❒ No

27. What would you like to talk to the nutritionist about today?

Thank you!