

Prenatal 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 became pregnant? Yes No
7. Is this your first pregnancy? Yes No
8. Has your doctor said that you have any health problems?
If "yes", list problem(s): Yes No
9. What concerns do you have about your health during this pregnancy?
10. Have you had any problems with your teeth or gums since you became pregnant? Yes No
11. Which of these do you have? nausea vomiting heartburn constipation none
12. 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
13. Which of these do you do?
 smoke cigarettes chew tobacco drink alcohol use drugs none
14. How do you feel about your weight change since you became pregnant?
 gaining too much gaining too little it's okay not sure weight has not changed
15. 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

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