Ohio Department of Health • Bureau of Nutrition Services
WIC Health History for Pregnant Women

Name

Today's date

Age

Your due date is

Weight before pregnancy

Number of past pregnancies

Number of live births

Date last pregnancy ended

Prenatal doctor or clinic

How far along were you at your first doctor visit for this pregnancy?

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
- [ ] 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
- [ ] No

How much?

List any medicines you take.
- [ ] None

Check all supplements you take.
- [ ] Prenatal vitamins
- [ ] Vitamins
- [ ] Iron
- [ ] Herbs
- [ ] Calcium
- [ ] Folic acid
- [ ] Other
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

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?
- [ ] None

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

Check all alcoholic beverages you drink.
- [ ] None

Check all drugs you used at any time during this pregnancy.
- [ ] None

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

Do you have any questions or concerns?
ASBI Screening Tool

1. Before you were pregnant, how often did you drink beer, wine, or other alcoholic beverages?
   □ 4 or more times a week
   □ 2-3 times a week
   □ 2-4 times a month
   □ Monthly or less
   □ Never

2. Currently, how often do you drink beer, wine, or other alcoholic beverages?
   □ 4 or more times a week
   □ 2-3 times a week
   □ 2-4 times a month
   □ Monthly or less
   □ Never

3. Currently, how many drinks do you usually have at one time?

   10 or more  9  8  7  6  5  4  3  2  1  0

4. Within the last month, how many times have you had 3 or more drinks at one time?

   10 or more  9  8  7  6  5  4  3  2  1  0

5. How many drinks does it take until you feel the effects of alcohol?

   10 or more  9  8  7  6  5  4  3  2  1

Stop here.