

PREGNANCY NUTRITION QUESTIONS

Name: _____	Age: _____
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Please circle or write your answers to the following questions:

1. When is your next doctor's appointment? _____
2. **What concerns does your doctor have about your pregnancy?** *Weight Gain* *Weight Loss*
What You Eat *High Blood Sugar* *High Blood Pressure* *Low Iron in Blood*
None *Other* _____
3. **Which of these do you take?** *Prenatal Vitamins* *Iron Pills* *Other Vitamins/Minerals*
Herbs *Laxatives* *Over the Counter Medications (Tylenol, Aspirin, etc.)* *None*
Other Medications _____ *Home Remedies (list)* _____
4. **What conditions do you have?** *Nausea* *Vomiting* *Heartburn* *Constipation*
Swelling *None* *Other (list)* _____
5. How do you feel about your weight change? *Too little* *OK* *Too much*

6. **How many times a day do you eat?** _____ *Meals* _____ *Snacks*
7. How many times a week do you eat fast food or food from a restaurant?
Never *1-2 times* *3-4 times* *5 or more times*
8. **Are you on a special diet?** *Yes* *No* *If yes, explain* _____
9. **Are there foods you limit or do not eat?** *Yes* *No* *If yes, list* _____
10. **What do you eat/drink on most days?**
 ♦ *Water* *Coffee* *Tea* *Regular Soda* *Diet Soda* *Gatorade*
 ♦ *Juice* *Punch/Kool Aid* *Alcohol* *Beer* *Wine*
 ♦ *Fruits* *Vegetables*
 ♦ *Milk (Skim/Lowfat/Whole)* *Cheese* *Yogurt* *Cottage Cheese* *Pudding/Custard*
 ♦ *Meat* *Chicken* *Turkey* *Fish* *Hotdogs* *Tofu* *Beans/Lentils* *Peanut Butter* *Eggs* *Nuts*
 ♦ *Breads* *Cereals* *Tortillas* *Rice* *Noodles* *Rolls* *Crackers* *Pan Dulce*
 ♦ *Candy* *Cookies* *Cakes* *Donuts* *Ice Cream* *Chips* *French Fries*
 ♦ *Other (list)* _____
11. **What things, other than food, do you crave to eat?** *Dirt* *Clay* *Ice* *Laundry Starch*
Cigarette Butts *Paint Chips* *None* *Other (list)* _____
12. How do you feel about your eating habits now? *Great* *Good* *OK* *Not so good*

13. Have you ever breastfed? *Yes* *No* *If yes, for how long?* _____
14. How confident are you that you will breastfeed your baby? (*Circle one*)
(not at all confident) *1.....* *2.....* *3.....* *4.....* *5* *(very confident)*
15. Are you employed or going to school? *Yes* *No* *Planning to Start*

16. What word(s) describe how you feel about being pregnant? *Happy* *OK* *Tired* *Depressed*
Sad *Stressed* *Angry* *Other* _____
17. What kind of activity do you do on most days? *Walk* *Run* *Bike* *Dance* *Sports* *Swim*
Exercise Class/Gym *Garden* *None* *Other (list)* _____
18. **Do you ever run out of money or food stamps to buy food?** *Yes* *No*
19. What nutrition and health questions do you have today?

For Staff Use Only

Date: _____ WIC Staff Name: _____

Participant WIC ID#: _____ Height: _____ Weight: _____