

## Nutrition & Activity Self-History Form: Pregnancy

Please complete the questions below about yourself.

Name: \_\_\_\_\_

Weeks Pregnant: \_\_\_\_\_ Pre-Pregnancy Weight: \_\_\_\_\_ (101,111,131,132, 133)

### Medical Information:

1. Do you have any medical problems today?  Cold  Nausea/Vomiting (301)  Heartburn  
 Anemia (201)  Constipation  Leg Cramps Other: \_\_\_\_\_ (341-349, 351,352, 354, 356, 358, 360)
2. Do you follow a special diet?  Yes  No  
If yes, what type of diet do you follow? \_\_\_\_\_ (358,362,427-.2..5))
3. What items do you take (check all that apply)?  Vitamins  Iron  Supplements/Herbs  Medicines  
Supplements/Herbs (please write in your supplements): \_\_\_\_\_ (427.1)  
Medicines (please write in your medicines): \_\_\_\_\_ (357)
4. Do you have any food allergies?  Yes  No  
If yes, please write in your food allergies: \_\_\_\_\_ (353, 355)
5. Have you been to see the doctor with this pregnancy?  Yes  No  
If yes, please write in your doctor's name: \_\_\_\_\_  
What month did you begin your prenatal care? \_\_\_\_\_ (334)
6. When was the last time you went to the dentist?  in the last 6 months  in the last year  don't remember (381)
7. How many times have you been pregnant? \_\_\_\_\_ How many live births have you had? \_\_\_\_\_ (331-333, 321,427)

If you have previously been pregnant, did you or your baby have any of the following conditions (check all that apply):

- Gestational Diabetes(302-303)  High Blood Pressure/Pregnancy Induced Hypertension(345)  Preeclampsia (304)  
 Bed Rest  Low Birth Weight Infant (312)  Premature Infant (311)  Other:\_\_\_\_\_
8. How many drinks with alcohol do you have per week? (372)  
None 1-2 drinks per week 3-4 drinks per week 5+ drinks per week
  9. How many cigarettes do you smoke? (371) None Special Occasions 1-2 cigarettes per day  
½ pack per day pack per day Trying to quit Other:\_\_\_\_\_
  10. How much weight do you plan on gaining with this pregnancy? \_\_\_\_\_ (131, 133)
  11. How do you plan on feeding your baby? (Circle all that apply) Breastfeeding Formula Not sure

### Please circle the answers to the questions below:

1. Food Choices - how many **times per day** do you:

- |   |               |               |               |               |
|---|---------------|---------------|---------------|---------------|
| a. Eat vegetables (not French fries)?                                 | 0-1 times/day | 2-3 times/day | 4-5 times/day | 6-7 times/day |
| b. Eat fruit?   | 0-1 times/day | 2-3 times/day | 4-5 times/day | 6-7 times/day |
| c. Eat fried food?  | 0-1 times/day | 2-3 times/day | 4-5 times/day | 6-7 times/day |
| d. Eat sweets and/or salty snacks?<br>(such as chips, candy, cookies) | 0-1 times/day | 2-3 times/day | 4-5 times/day | 6-7 times/day |
| e. Drink water?   | 0-1 times/day | 2-3 times/day | 4-5 times/day | 6-7 times/day |
| f. Drink 100 % WIC juice?   | 0-1 times/day | 2-3 times/day | 4-5 times/day | 6-7 times/day |
| g. Drink soda or sweetened drinks?                                    | 0-1 times/day | 2-3 times/day | 4-5 times/day | 6-7 times/day |

h. Circle the type of milk you drink most often:

Whole      2%      1%      Non—fat/Skim      Soy      Other types of milk (chocolate, etc.)  
Rarely drink milk      Never drink milk      Other

2. Meal Patterns – how many **days per week** do you:

- |   |             |             |             |             |
|---|-------------|-------------|-------------|-------------|
| a. Eat breakfast?                             | 0-1 days/wk | 2-3 days/wk | 4-5 days/wk | 6-7 days/wk |
| b. Eat a meal with the family?                | 0-1 days/wk | 2-3 days/wk | 4-5 days/wk | 6-7 days/wk |
| c. Eat food from a fast food restaurant?      | 0-1 days/wk | 2-3 days/wk | 4-5 days/wk | 6-7 days/wk |
| d. Eat meals or snacks in front of the TV?    | 0-1 days/wk | 2-3 days/wk | 4-5 days/wk | 6-7 days/wk |
| e. Eat seafood (other than trout or catfish)? | 0-1 days/wk | 2-3 days/wk | 4-5 days/wk | 6-7 days/wk |

3. Nutrition Habits

- a. How would you describe your eating?    OK      Picky      Eat too much      Eat too little  
    Won't try new things

Eating habits you have changed since becoming pregnant: \_\_\_\_\_

- b. Do you ever eat any of the following? (Circle all that apply) (427.5)

Raw Milk    Sprouts    Imported Cheese (Camembert, Brie, Blue-Veined or Mexican Style Cheese)

Cold Deli Meats    Cold Hot Dogs    Raw Fish or Shellfish    Unpasteurized fruit or Vegetable Juice

- c. What things, other than food, do you eat? (Check all that apply) (427)    Ice    Dirt    Clay

Cigarette Butts    Paint Chips      Laundry Starch      Cornstarch      Other: \_\_\_\_\_

4. Activity and Schedule

- a. How many **days per week** do you participate in activity such as walking, dancing, gardening, or other exercise?

0-1 days/wk      2-3 days/wk      4-5 days/wk      6-7 days/wk

- b. When you do participate in activity, how much time do you spend in these activities each time?

10-20 minutes      20-30 minutes      30-60 minutes      60 + minutes

How many **hours per day** do you:

- a. Watch TV?      Less than 1 hour/day      1-2 hours      3-4 hours      5 or more hours

- b. Use computer and play video games?

Less than 1 hour/day      1-2 hours      3-4 hours      5 or more hours

5. Concerns: Are you concerned about your weight gain? (101, 111)       Yes       No

Do you feel you are:

not gaining enough weight    gaining a healthy amount of weight    gaining too much weight

Are you concerned about your eating habits?       Yes       No

Are you concerned about your activity level?       Yes       No

Do you often run out of money or food stamps to buy food?       Yes       No       Sometimes

Do you have other concerns you would like to discuss today?       Yes       No

Please write other concerns here: \_\_\_\_\_  
\_\_\_\_\_

**STOP HERE. Thank you for answering these questions. Please return the completed form to the WIC clerk.**