

# **Nutrition & Activity Self-History Form: Postpartum/Breastfeeding**

**Please complete the questions below about yourself.**

**Name:** \_\_\_\_\_ **Date of mother's birth:** \_\_\_\_\_ (331, 333)

Date of Delivery: \_\_\_\_\_ Pre-Pregnancy Weight: \_\_\_\_\_ (101, 111) Weight Gain in Pregnancy: \_\_\_\_\_ (133)

Number Weeks Pregnant at Delivery: \_\_\_\_\_ Infants Birth Weight: \_\_\_\_\_ Date last pregnancy ended \_\_\_\_\_ (332)

Twins: \_\_\_\_\_ (335)

## **Medical Information:**

1. Do you have any medical problems today?  Cold  Anemia (201)  C-Section at delivery (359,337)  
 Constipation  Diarrhea Other: \_\_\_\_\_
2. What items do you take (check all that apply)?  Vitamins  Iron  
 Supplements/Herbs (please write in your supplements): \_\_\_\_\_ (357, 427.1)  
 Medicines (please write in your medicines): \_\_\_\_\_ (357)
3. Do you have any food allergies?  Yes (353)  No  
If yes, please write in your food allergies: \_\_\_\_\_
4. Have you been to see the doctor since you delivered?  Yes  No  6 week postpartum appointment  
If yes, please write in your doctor's name: \_\_\_\_\_
5. Are you interested in learning more about birth control options?  Yes  No
5. When was the last time you went to the dentist?  in the last 6 months  in the last year (381)  don't remember
6. In your previous pregnancy, did you have any of the following conditions (check all that apply):  
 Gestational Diabetes (303)  High Blood Pressure/Pregnancy Induced Hypertension(345)  Preeclampsia (304)  
 Low Birth Weight (312)  Prematurity (311)  Other: \_\_\_\_\_ (321)
7. How many drinks with alcohol do you have per week?  
 None  1-2 drinks per week (372)  3-4 drinks per week  5+ drinks per week
8. How many cigarettes do you smoke?  None  Special Occasions (371)  1-2 cigarettes per day  
 ½ pack per day  pack per day  Other : \_\_\_\_\_  Trying to quit  Family member smokes (904)

**Family History:** Do any family members have any of the following health conditions?:

<u>Health Condition:</u>	<u>Circle the family member(s) with the health condition:</u>					
Diabetes	Mother	Father	Grandparent	Aunt	Uncle	None/don't know
Heart Disease / Heart Attack	Mother	Father	Grandparent	Aunt	Uncle	None/don't know
High Blood Pressure	Mother	Father	Grandparent	Aunt	Uncle	None/don't know
Obesity	Mother	Father	Grandparent	Aunt	Uncle	None/don't know
Stroke	Mother	Father	Grandparent	Aunt	Uncle	None/don't know

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

1. Food Choices - how many **times per day** do you: (427.2,.4,.5)
  - 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?*  0-1 times/day  2-3 times/day  4-5 times/day  6-7 times/day  
(such as chips, candy, cookies)

- e. *Drink water?*  0-1 times/day  2-3 times/day  4-5 times/day  6-7 times/day
- f. *Drink juice?*  0-1 times/day  2-3 times/day  4-5 times/day  6-7 times/day
- g. *Drink soda or sweetened fruit drinks?*  0-1 times/day  2-3 times/day  4-5 times/day  6-7 times/day
- h. *What type of milk do you drink most often:*  
 Whole  2%  1%  Non-fat/Skim  Soy  Other types of milk (chocolate, etc.)  
 Rarely drink milk  Never drink milk (355)  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 “fast food” meals?*  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 except trout or catfish?(427.5)*  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

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. Feeding your baby

- a. How are you feeding your baby? (Check all that apply)  Breastfeeding  Formula
- b. Do you have any concerns with feeding your baby?  Yes  No

If you are currently breastfeeding your baby, please answer the following questions:

- c. Are you comfortable with breastfeeding your baby?  Yes  No
- d. Do you feel your baby is getting enough to eat?  Yes  No (601, 602)
- e. Do you plan to return to work and continue breastfeeding?  Yes  No
- f. How long do you plan on breastfeeding your baby? \_\_\_\_\_

6. Concerns: Are you concerned about your weight? (101, 111)  Yes  No
- Would you like to know your weight today?  Yes  No
- Are you concerned about your eating habits?  Yes  No
- Are you concerned about your activity level?  Yes  No
- Are you concerned about the weight or eating habits of any of your children?  Yes  No
- Do you have other concerns you would like to discuss today?  Yes  No
- Do you often run out of money or food stamps to buy food?  Yes  No  Sometimes
- Please write other concerns here: \_\_\_\_\_

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