



# Pregnant Women Application

<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Birth Date</b> <small>331,332,333</small>	<b>Due Date</b>	<b>Today's Date</b>
<b>Social Security Number</b>			<b>Is this person Hispanic or Latino?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Select at least one of the following:</b>					
<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Asian		<input type="checkbox"/> White	
<input type="checkbox"/> Black/African American		<input type="checkbox"/> Native Hawaiian/Pacific Islander			

## WIC helps families with healthy food and nutrition choices.

How is your pregnancy going? Please, tell us if you have any concerns.

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1. Please, tell us if you see a doctor, dietitian or health care provider for medical or emotional reason(s), **ex: fetal growth restriction, hypertension, pre-hypertension, gestational diabetes, anemia or gastrointestinal disorders,** 201, 211, 302, 336, 341-349, 351-362  
Describe: \_\_\_\_\_
  2. **If you were in the hospital in the last 3 months, please, tell us why.** 359  
\_\_\_\_\_
  3. **Have you been screened or referred for lead poisoning?**    No    Yes 211
  4. Write the date of your last dental check-up \_\_\_\_\_ 381
  5. Tell us if you have any problems eating any type of food for any reason such as dental problems, food intolerances, food allergies or others? 353-355, 381  
Describe: \_\_\_\_\_
  6. List any medication, vitamin, pre-natal vitamins, mineral or herbal supplement you are taking. 357, 427.01  
\_\_\_\_\_  
If not daily, how often? \_\_\_\_\_ 427.04  
\_\_\_\_\_
  7. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home?    No    Yes 904
  8. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping?    No    Yes 801
  9. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals?    No    Yes 801
  10. Did a family member have a seasonal farming job with a temporary home in the last 24 months?    No    Yes 802
  11. Are you in a relationship with anyone who pushes, hits or threatens you in any way?    No    Yes 901
  12. What problems, if any, do you have caring for yourself or your baby/children? 902  
Describe: \_\_\_\_\_
  13. Circle the type of milk you would like on your WIC checks or in your food box:  

<b>Fresh</b>	<b>Fluid (UHT)</b>	<b>Evaporated</b>
<b>Soy</b>	<b>Lactose Reduced 355</b>	<b>Dry</b>
  14. What concerns, if any, do you have about having enough food to feed your family?  
Comment: \_\_\_\_\_
  15. **How do you plan to feed your baby?**  
 Breastmilk    Breastmilk/Formula  
 Formula    Unsure  
Have you breastfed before?    No    Yes  
Are you breastfeeding another child?    No    Yes 338
  16. On a scale of 0 to 10, how ready do you feel about breastfeeding your baby? (Circle a number)  
**Not Ready 0 1 2 3 4 5 6 7 8 9 10 Ready**

**\*\*\*To Be Completed by Health Care Provider (HCP)\*\*\***

Medical date \_\_\_\_\_ Ht \_\_\_\_\_ Pre-Pregnancy Wt \_\_\_\_\_ (101, 111) Current Wt \_\_\_\_\_ (131, 132, 133) Hgb /Hct \_\_\_\_\_ (201)

**Name of HCP verifying applicant lives in Alaska** \_\_\_\_\_ **ID Verified by:** Visual Recognition \_\_\_/Other \_\_\_\_\_ WIC

**Name of CPA reviewing WIC application** \_\_\_\_\_ **Certification Date** \_\_\_\_\_



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17. On a scale of 0 to 10, how well do think you are eating?  
(Circle a number)

Not Well 0 1 2 3 4 5 6 7 8 9 10 Very Well

I usually eat \_\_\_meals /day and \_\_\_snacks/day.

I usually eat fruits/vegetables:  1 cup/day or less

2 cups/day

3 cups/day or more

18. **Check the box and circle the foods you eat.** 427.05

Raw or undercooked meat, poultry, fish, eggs

Foods with raw or undercooked eggs, like salad dressings, cookie and cake batters, sauces

Hot dogs, luncheon meats, fermented and dry sausage, unheated deli-style meat or poultry

Refrigerated Smoked Seafood (unless it is cooked)

Soft cheeses made with un-pasteurized milk: Feta, Mexican style (queso blanco fresco), Brie, Blue

Raw sprouts (alfalfa, clover and radish)

Un-pasteurized milk, fruit or vegetable juice or foods made with Un-pasteurized milk

19. **Circle if you crave or eat:**

Ashes                      Baking Soda                      Dust  
Carpet Fibers              Chalk    Cigarettes              Soil  
Clay                      Starch (laundry or corn starch)  
Paint Chips              Burnt Matches  
Large quantities of ice and/or freezer frost 427.03

20. Do you fast, binge, vomit to control your weight or to follow a specific diet?  No  Yes 358/427.02

Describe \_\_\_\_\_

21. Do you smoke cigarettes, pipes or cigars?  No  Yes 371

If yes, how many a day \_\_\_\_\_

22. Do you use smokeless, chewing tobacco or iqmik?  No  Yes

If yes, how many times per day? \_\_\_\_\_

23. Do you drink wine, beer or other alcoholic beverages during this pregnancy?  No  Yes 372

If yes, how many drinks a day? \_\_\_\_\_

If yes, how many drinks a week? \_\_\_\_\_

24. **Check any drugs you are using during this pregnancy** 372

Marijuana               Methadone               Cocaine

Crank               Crack Methamphetamine               Speed

Heroin               Other               None               Stopped Using

If stopped using, when was the last time you used?  
\_\_\_\_\_

25. The date I started seeing a doctor for this pregnancy was: \_\_\_\_\_ 334, 503

I have not started seeing a doctor for this pregnancy.

26. When was your last pregnancy? \_\_\_\_\_ 332

27. How many babies are you expecting? \_\_\_\_\_ 335

28. How many times have you been pregnant? (do not count this pregnancy) \_\_\_\_\_ times  
How old are your children? \_\_\_\_\_ 333

29. **Check any problems you had with any of your pregnancies:**

Never pregnant before/ or didn't have problems

Baby born 3 or more weeks early 311

Baby, less than 5 pounds 9 oz. at birth 312

Miscarried – how many \_\_\_\_\_ 321

Baby, more than 9 pounds at birth 337

Stillbirth – how many \_\_\_\_\_ 321

Genetic or birth defects 339

Abortions – how many \_\_\_\_\_

Baby died before 1 month old 321

C-Section 359

History of Gestational Diabetes 303

History of Preeclampsia 304

30. **Check if you are having any of the following problems with this pregnancy** (if it applies):

Nausea                       Vomiting 301

Constipation               Heartburn 342

31. How often do you feel down, depressed or hopeless? 361

Never               Rarely               Sometimes               Often               Always

32. What does your family do for fun? \_\_\_\_\_

33. **How can WIC help your family today?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_