Breastfeeding/Postpartum Women Application

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date ________________

1. Name (First, Middle, Last)

2. Birth Date — 331 332 333

3. If receiving Medicaid, please provide Medicaid number:

4. Is this person Hispanic or Latino? ☐ Yes ☐ No

5. Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Current History

6. How are you doing after having your baby? Please tell us if you have any concerns?

7. What was the actual date your baby was born?

8. What was your baby's weight at birth? What was the baby's length at birth?

9. At what Birthing Facility was the child born?

10. How many weeks did your pregnancy last?

11. When did your Prenatal care begin? (Month, Year)

12. How far apart were your last two pregnancies? 332

13. How many babies did you have during your last pregnancy? 335

14. How many times have you been pregnant? (Do not count this pregnancy)

15. How old are your children? 333

16. How much did you weigh before pregnancy?

17. Check it you had any of the problems during your recent pregnancy?

☐ Miscarried - How many? ________________ 321
☐ Stillbirth - How many? ________________ 321
☐ More than one baby How many? ________________ 335
☐ Baby born 3 or more weeks early 311
☐ Baby, less than 5 pounds 9 oz at birth 312
☐ Baby, 9 pounds or more at birth 337
☐ Baby died before 1 month old 321
☐ Genetic or birth defects 339
☐ C-section 359
☐ History of Gestational Diabetes 303
☐ History of Preeclampsia 304

18. List any medication, vitamin, prenatal vitamins, mineral or herbal supplement you are taking. If not daily, how often? 357 427.01 427.04

19. Please, tell us if you see a doctor, dietitian or health care provider for medical or emotional reason(s) ex: hypertension, pre-hypertension, pre-diabetes, diabetes, anemia or gastrointestinal disorders. 201 302-304 341-349 351-363

Describe:

20. If you were in the hospital in the last 3 months, please tell us why. 359

Cigarette, Alcohol, Drug Usage

21. Do you smoke cigarettes, pipes or cigars? ☐ Yes ☐ No If yes, How much a day? 371

22. Did you smoke in the last 3 months of your pregnancy? ☐ Yes ☐ No If yes, How many a day?

23. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home? ☐ Yes ☐ No 904

24. Do you use smokeless, chewing tobacco or iqmik? ☐ Yes ☐ No If yes, How much a day?

25. Did you drink alcohol in the last 3 months of your pregnancy? ☐ Yes ☐ No If yes, How many a week? 371

26. Do you drink, wine, beer, or other alcoholic beverages? ☐ Yes ☐ No If yes, How many a day? If yes, How many a week? 372

To Be Completed by Health Care Provider (HCP)

Medical date__________Ht________ Pre-Pregnancy Wt__________(101,111) Weight Before Delivery__________Current Wt__________(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______________________________________

27. Check any drugs you are using during this pregnancy:

- [ ] Cocaine
- [ ] Crack Methamphetamine
- [ ] Marijuana
- [ ] Speed
- [ ] Other ____________________
- [ ] Crank
- [ ] Heroin
- [ ] Methadone
- [ ] None
- [ ] Stopped Using When? ____________

Eating & Feeding

28. What concerns, if any, do you have about having enough food to feed your family?

29. How are you feeding your baby? ☐ Breastmilk ☐ Breastmilk+Formula ☐ Formula Only

30. **If breastfeeding**, what date did it begin? When did breastfeeding end?

31. What was the reason that breastfeeding was stopped?

32. On a scale of 0 to 10,
How confident are you about breastfeeding your baby? Not Confident ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Confident

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a. How long do you plan to breastfeed?____________________

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b. I breastfeed__________ times in 24 hours and each feeding lasts __________ minutes.

33. **If formula only**, did you ever breastfeed? ☐ Yes ☐ No If yes, how long? (i.e. days or weeks)

34. When did you introduce formula?

35. On a scale of 0 to 10,
How well do you think you are eating? Not Well ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Well

a. I usually eat __________ meals/day and __________ snacks/day.
b. I usually eat fruits: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more
c. I usually eat vegetables: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more

36. Check if you crave or eat 427.03

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

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

Describe:

38. Do you have any problems eating any type of food for any reason such as dental problems, food intolerances, food allergies or others?

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Additional

39. Have you been screened or referred for lead poisoning? ☐ Yes ☐ No 211

40. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping? ☐ Yes ☐ No 801

41. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals? ☐ Yes ☐ No 801

42. Did a family member have a seasonal farming job with a temporary home in the last 24 months? ☐ Yes ☐ No 802

43. Are you in a relationship with anyone who pushes, hits or threatens you in any way? ☐ Yes ☐ No 901

44. How often do you feel down, depressed or hopeless? ☐ Never ☐ Sometimes ☐ Often ☐ Always 361

45. What type of milk you would like on your WIC check?
☐ Fresh/Refrigerated ☐ Boxed (UHT) ☐ Soy ☐ Dry ☐ Evaporated ☐ Lactose Reduced 355

46. What problems, if any do you have caring for yourself or your baby/children? 902

47. Write the date of you last dental check-up: (Month, Year) 381

48. What does your family do for fun?

49. How can WIC help your family today?

Thank You!

Revised: 5/24/19