Certification: Pregnancy

WIC ID: _____ **Name:** _____

Cardholder: _____ **Today's date:** _____

Weight: ____ **Height:** ____ **Hgb:** _____ **Weight before this pregnancy:** _____

Estimated Due Date: _____ or Last Menstrual Period: _____

Twins or more: ❑ Yes ❑ No

The format of the questions follows what is seen in TWIST.

Note: Bolded questions are mandatory TWIST questions

Health History

01 Tell me about your health or pregnancy

02 Is this your first pregnancy?

❑ Yes (skip to question 3)

❑ No (please answer mandatory questions **2.2 through 2.7 below**)

02.2 For births after 20 weeks, were any stillbirths or neonatal deaths? (321)

❑ No ❑ Yes

02.3 Were any babies born at or before 38 weeks? (311)

❑ No ❑ Yes

02.4 Did any of your babies weigh 5 pounds 8 ounces or less at birth? (312)

❑ No ❑ Yes

02.5 Did any of your babies weigh 9 pounds or more at birth? (337)

❑ No ❑ Yes

02.6 What was the date your last pregnancy ended?

02.7Are there less than 18 months between the end of the last pregnancy and the beginning of this pregnancy? (332)

❑ No ❑ Yes

03 When did you start going to a doctor or clinic for prenatal care for this pregnancy? (334)

❑ No care yet, in the 1st trimester

❑ No care yet, in the 2nd or 3rd trimester

❑ Month care started:

04 Have you had any medical problems with this or any previous pregnancy? (300+)

❑ No

❑ Yes (please list)

05 Do you take any medications now? (357)

❑ Yes, there are drug nutrient interactions

❑ Yes, but no nutritional impacts

❑ No

06 Are you currently smoking cigarettes or vaping? (371)

❑ No ❑ Yes – referral made, describe:

07 Have you been in an enclosed space while someone was smoking cigarettes or vaping? (904)

❑ No ❑ Yes

08 Have you had any beer, wine or hard liquor to drink during this pregnancy? (372)

❑ No

❑ Yes – referral made, describe:

09 Have you used any drugs during this pregnancy? (372)

❑ No ❑ Yes – referral made, describe:

10 Do you have any concerns about your safety at home or in your relationships? (901)

❑ No

❑ Unable to ask question

❑ Yes

11 How do you plan to feed your baby after they are born?

❑ Both breast and formula feed ❑ Breastfeed

❑ Formula feed ❑ Undecided

12 What have you heard about breastfeeding?

Diet Assessment

01.1 What changes have you made to your eating habits since becoming pregnant?

01.2 What have you heard about eating during pregnancy?

01.3 On a typical day, what meals, snacks, and beverages would you have?

02.0 Do you have any discomforts with eating during this pregnancy?

❑ No (skip to 03.1) ❑ Yes (complete 02a-02f)

02a Constipation or Diarrhea? ❑ No ❑ Yes

02b Nausea and/or Vomiting? ❑ No ❑ Yes

02c Heartburn? ❑ No ❑ Yes

02d Poor Appetite? ❑ No ❑ Yes

02f Other ❑ No ❑ Yes, describe:

03.1 How do you feel about the weight changes you have had with this pregnancy?

03.3 In the past few months, were there times when your family ran low on food?

❑ No ❑ Yes

04.1 What foods, if any, do you avoid for health or other reasons?

05.1 Are you on a low calorie or restricted diet? (427.2)

❑ No
❑ Vegan
❑ Macrobiotic
❑ Low Carbohydrate/High Protein
❑ Other:

06.1 Do you eat anything that is not food? (427.3)

❑ No ❑ Yes, describe:

06.6 Do you eat raw or undercooked meat, poultry, fish or eggs? (427.5)

❑ No ❑ Yes, describe:

06.8 Do you use unpasteurized dairy products or juice? (427.5)

❑ No ❑ Yes, describe:

07.1 What vitamins or other supplements do you take? (427.4)

❑ Vitamin or supp with iron & iodine
❑ None or supp with iron & iodine
❑ Unknown

NE Provided:

Next Step:

Food Package Notes: (modifications, etc)

Quarterly NE Plan/Next Appointment Type: