



Breastfeeding/Postpartum Application

WIC is here to help you eat well, be active and stay healthy during your child-bearing years. The information you share will guide us on how to best serve you.

Name (First, Middle, Last) _____

Your Date of Birth ^{331, 332, 333} _____

Today's date _____

Social Security #: _____

Race: Is this person Hispanic or Latino? No Yes

You must also select at least one of the following: American Indian/Alaska Native Asian White
 Black/African American Native Hawaiian/Pacific Islander

1. How many babies did you just have? 1 2 3 or more *List the number* _____ ³³⁵

2. Was your baby born 3 or more weeks early? No Yes, _____ weeks early ¹⁴²

3. Baby(ies) birth date: _____ Baby(ies) birth weight(s): _____ ^{337, 141}

Check if you had: Miscarriage or Pregnancy Ended Baby died in first month ³²¹

How are you feeding your baby? Feeding is a good way for you & your baby to get to know each other.

4. Breastfeeding Breastfeeding + Formula Formula only*

* If breastfeeding only, how long would you like to breastfeed your baby? _____

* If formula only, did you ever breastfeed? No Yes → _____ days or _____ weeks ⁷⁰¹

• I introduced formula at _____ weeks

• How many times in 24 hours are you breastfeeding? _____ times ^{601, 602}

• Each feeding lasts _____ minutes.

• How confident are you about breastfeeding your baby? (circle a number below)
not confident 0 1 2 3 4 5 6 7 8 9 10 very confident

• How long would you like to breastfeed your baby? _____

5. If formula feeding: how much formula does your baby drink during 24 hours _____ oz

6. What concerns or questions do you have about feeding your baby?

7. Are you seeing a doctor or dietitian for any medical problems? No Yes ^{341-349; 351-362}

Describe: _____

8. In the last 3 months, have you been to the hospital for any reason (besides baby's birth)?

No Yes → Emergency room Hospital overnight Surgery ³⁵⁹

If any, describe: _____

9. Do you see a dentist for regular check-ups? No Yes, Date of Last Visit: _____ ³⁸¹

10. Check any problems you had during **this** pregnancy or delivery:

C-Section ³⁵⁹ Anemia ²⁰¹ High blood pressure ³⁴⁵ Diabetes ^{303, 343}

None apply Other: _____

11. List any medication, vitamin, mineral, or herbal supplement you are taking:

_____ ^{427.1, 427.4}

12. Would you like more information on birth control or family planning? No Yes **next page** →

*****To Be Completed by Health Care Provider*****

Application reviewed by _____ Medical date _____ Certification Date _____

Ht _____ Wt _____ Pre-PG wt _____ BMI _____ ^{101, 111, 133} Hgb /Hct _____ ²⁰¹ Staff initials _____

Additional questions for Post-Partum & Breastfeeding applicants.

Complete only if not on WIC at this clinic during your most recent pregnancy.

Name (First, Last) _____

Your Date of Birth ^{331, 332, 333} _____

Today's date _____

1. How many times have you been pregnant, including this pregnancy? _____ times

Ages of your children: _____

2. Check any of the following problems you had with ***any*** pregnancies (*check all that apply*):

- Never pregnant before
- Baby born 3 or more weeks early ³¹¹
- Had no problems with my pregnancies
- Small baby, less than 5 pounds 8 oz. at birth ³¹²
- Miscarriage – how many _____ ³²¹
- Large baby, more than 9 pounds at birth ³³⁷
- Stillbirth – how many _____ ³²¹
- Genetic or birth defect ³³⁹
- Abortions – how many _____
- Baby died before 1 month old ³²¹
- Other _____

Avoiding tobacco, alcohol and illegal drugs will help keep you & your family healthy.

Please tell us more about these habits.

3. In the 3 months before getting pregnant this time:

- Did you drink alcohol? No Yes ³⁷²
- If yes, on average, how many drinks a day? _____ How many days a week? _____ ³⁷²
- Did you smoke? No Yes If yes, how many cigarettes a day? _____ ³⁷¹
- Did you use smokeless or chewing tobacco? No Yes → how many times per day? _____ ³⁷¹

4. **During this pregnancy:**

- Did you drink alcohol? No Yes _____ drinks a day _____ days a week ³⁷²
- Did you smoke? No Yes _____ cigarettes a day
- Did you use smokeless or chewing tobacco? No Yes → how many times per day? _____ ³⁷¹

5. Mark any of these drugs you used:

- Cocaine
- Crank
- Crack
- Marijuana
- Methadone
- Speed
- Heroin
- Other _____ ³⁷²
- Methamphetamine
- None
- None now, but in the past. *how long ago?* _____

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

7. On the average, about how many days/week is there smoking anywhere inside your home? ___ ⁹⁰⁴

8. Did you have any medical conditions or problems during your most *recent* pregnancy?

No Yes → please explain: _____

Thank you.