



# 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
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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?

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

15. How old are your children?

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16. How much did you weigh before pregnancy?

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

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

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

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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.

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302-304  
341-349  
351-363

Describe:

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

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## Cigarette, Alcohol, Drug Usage

21. Do you smoke cigarettes, pipes or cigars?

Yes  No If yes, How much a day?

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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

a. How long do you plan to breastfeed? \_\_\_\_\_

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b. I breastfeed \_\_\_\_\_ times in 24 hours and each feeding lasts \_\_\_\_\_ minutes.

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602

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

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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? \_\_\_\_\_

353-355  
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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 <sup>355</sup>

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? \_\_\_\_\_