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

601

a. How long do you plan to breastfeed?_____

601,602

b. I breastfeed_____ times in 24 hours and each feeding lasts _____ minutes.

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

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?

353-355
381

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