



Pregnant 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. Due Date
-------------------------------	---------------	-------------------	-------------

4. If receiving Medicaid, please provide Medicaid number:

5. Is this person Hispanic or Latino? Yes No

6. Race (Check all that apply)

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

Current History

7. How is your pregnancy going? Please tell us if you have any concerns.

8. The date I started seeing a doctor for this pregnancy was? I have not started seeing a doctor for this pregnancy. 334
503

9. When was your last pregnancy? (Month, Year) 332
10. How many babies are you expecting? 335

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

12. How old are your children? 333

13. How much did you weigh before pregnancy?

14. Are you breastfeeding another child? Yes No 338

15. Check any problems you had with any of your pregnancies?

<input type="checkbox"/> Never pregnant before or didn't have problems	<input type="checkbox"/> Baby born 3 or more weeks early	311	<input type="checkbox"/> Genetic or birth defects	339
<input type="checkbox"/> Miscarried - 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"/> Stillbirth - How many? _____ 321	<input type="checkbox"/> Baby, 9 pounds or more at birth	337	<input type="checkbox"/> History of Gestational Diabetes	303
<input type="checkbox"/> Abortions - How many? _____	<input type="checkbox"/> Baby died before 1 month old	321	<input type="checkbox"/> History of Preeclampsia	304

16. Check if you are having any of the following problems with this pregnancy: 301
 Constipation Heartburn Nausea Vomiting 342

17. Did you take vitamins before your pregnancy? Yes No If yes, how often?

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) 201, 211
ex: fetal growth restriction, hypertension, prehypertension, gestational diabetes, diabetes, anemia or gastrointestinal disorders. 302
336
341-349
351-362

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 before your pregnancy? Yes No If yes, How many a day?

23. Did you smoke cigarettes, pipes or cigars at any time during this pregnancy? Yes No 371

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

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

26. Did you drink alcohol before your pregnancy? Yes No If yes, How many a week?

27. Did you drink wine, beer or other alcoholic beverages during this pregnancy? Yes No If yes, How many a day? 372
If yes, How many a week?

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 _____

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

372

- Cocaine Crack Methamphetamine Marijuana Speed Other _____
 Crank Heroin Methadone None Stopped Using When? _____

Eating & Feeding

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

30. How do you plan to feed your baby? Breastmilk Breastmilk/Formula Formula Unsure

a. Have you breastfeed before? Yes No

31. On a scale of 0 to 10,

How ready do you feel about breastfeeding your baby? Not Ready 0 1 2 3 4 5 6 7 8 9 10 Ready

32. 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

33. Check the box if you are eating any these foods.

427.05

- Raw sprouts:** alfalfa, clover and radish **Food with raw or undercooked eggs:** salad dressing, cookie and cake batter, sauces
 Raw or undercooked: meat, chicken, turkey, fish, eggs **Soft cheese made with unpasteurized milk:** feta, mexican-style (queso blanco fresco), brie, blue
 Uncooked refrigerated smoked seafood **Unpasteurized** milk or foods made with unpasteurized milk
 Unheated meats: lunch meats, deli-style meat or chicken, fermented and dry sausage, raw hot dogs **Unpasteurized** fruit or vegetable juice

34. Check if you crave or eat any of the following:

427.03

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

35. Do you fast, binge, vomit to control your weight or follow a specific diet? Yes No

358
427.02

Describe:

36. 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

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

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

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

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

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

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

43. What type of milk you would like on your WIC check?

- Fresh/Refrigerated Boxed (UHT) Soy Dry Evaporated Lactose Reduced ³⁵⁵

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

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

46. What does your family do for fun?

47. How can WIC help your family today?