Pregnant Women Application

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

1. Name (First, Middle, Last)

2. Birth Date

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.

   I have not started seeing a doctor for this pregnancy.

   The date I started seeing a doctor for this pregnancy was?  

   When was your last pregnancy? (Month, Year)

10. How many babies are you expecting?

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

12. How old are your children?

13. How much did you weigh before pregnancy?

14. Are you breastfeeding another child?  Yes  No

15. Check any problems you had with any of your pregnancies?
   - Never pregnant before or didn't have problems
   - Miscarried - How many?  
   - Stillbirth - How many?  
   - Abortions - How many?  
   - Baby born 3 or more weeks early
   - Baby, less than 5 pounds 9 oz at birth
   - Baby, 9 pounds or more at birth
   - Baby died before 1 month old
   - Genetic or birth defects
   - C-section
   - History of Gestational Diabetes
   - History of Preeclampsia

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

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?

19. Please, tell us if you see a doctor, dietitian or health care provider for medical or emotional reason(s)
   ex: fetal growth restriction, hypertension, prehypertension, gestational diabetes, diabetes, anemia or gastrointestinal disorders.

   Describe:

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

Cigarette, Alcohol, Drug Usage

21. Do you smoke cigarettes, pipes or cigars?  Yes  No  If yes, How much a day?

22. Did you smoke before your pregnancy?

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

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

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?  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:

- [ ] 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
- [ ] Ready

32. On a scale of 0 to 10, how well do you think you are eating?

- [ ] Not Well
- [ ] 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.

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

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

- [ ] 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

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?

- [ ] Yes
- [ ] No

**Additional**

37. Have you been screened or referred for lead poisoning?

- [ ] Yes
- [ ] No

38. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping?

- [ ] Yes
- [ ] No

39. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals?

- [ ] Yes
- [ ] No

40. Did a family member have a seasonal farming job with a temporary home in the last 24 months?

- [ ] Yes
- [ ] No

41. Are you in a relationship with anyone who pushes, hits or threatens you in any way?

- [ ] Yes
- [ ] No

42. How often do you feel down, depressed or hopeless?

- [ ] Never
- [ ] Sometimes
- [ ] Often
- [ ] Always

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

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

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

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

46. What does your family do for fun?

47. How can WIC help your family today?

Thank You!

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