

Postpartum Woman Nutrition Questionnaire

Name: _____	Age: _____
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Please circle or write your answers to the following questions:

1. What is something that you do to be healthy? _____
2. What would you like to talk about today? _____

Your Eating Habits

3. How do you feel about how you are eating now? *Good* *OK* *Not so good* *Other* _____
4. How many meals do you eat each day? _____ How many snacks? _____
5. How many times a **week** do you eat out or eat take-out food? *0* *1* *2* *3* *4* *5* *6* *7* *more*

Drinks and Foods

6. What do you drink on **most days**? *Water* *Milk* *Juice* *Soda* *Coffee* *Tea* *Flavored water*
Fruit drinks *Kool-Aid or Punch* *Diet drinks* *Energy drinks* *Sports drinks* *Soy milk*
Wine *Beer* *Alcohol* *Other* _____
7. What do you eat on **most days**? *Whole wheat bread* *Corn tortillas* *Whole wheat tortillas* *Brown rice*
Cold or hot cereal *White bread* *Flour tortillas* *White rice* *Pasta/Noodles* *Crackers*
Vegetables (which?) _____ *How many each day?* _____
Fruits (which?) _____ *How many each day?* _____
Beef *Pork* *Chicken* *Turkey* *Fish* *Eggs* *Beans* *Peanut butter* *Nuts* *Tofu*
Nonfat milk *Lowfat milk* *Whole milk* *Flavored milk* *Cheese* *Yogurt* *Cottage cheese*
French fries *Chips* *Hot dogs* *Deli meats* *Nuggets* *Desserts/sweets* *Other* _____
8. Are you on a special diet? *No* *Yes (please explain)* _____
9. Are there any foods that you limit or avoid? *No* *Yes (please explain)* _____

Additional Questions

10. Do you have: *Diabetes (high blood sugar)* *High blood pressure* *Anemia (low iron in blood)*
Mental health issues *Depression* *Other* _____ *None*
11. How do you feel about your weight? *Want to lose weight* *OK* *Want to gain weight*
12. Which of these do you take? *Prenatal vitamins* *Multivitamins with folic acid* *Other vitamins/minerals*
Iron pills *Laxatives* *Herbs* *Over the counter medicines* *Prescription medicines*
Home remedies *Other* _____ *None*
13. How have you been feeling? *Not interested in doing things* *Sad* *Depressed* *Hopeless* *No energy*
Happy *OK* *Lonely* *Overwhelmed* *Stressed* *Anxious* *Angry* *Other* _____
14. What kinds of physical activities do you do? _____ How often? _____
15. If breastfeeding, how is it going for you? _____
16. What support will you need to keep breastfeeding if you return to work or school? *Pump* *Other* _____
17. Do you plan to have more children? *No* *Not sure* *Yes (when?)* _____
18. What plans do you have for birth control? _____
19. When is your next doctor's appointment? _____ Last dentist appointment? _____
20. Do you ever run out of food? *No* *Yes (what do you do?)* _____
21. What questions or concerns do you have about shopping for WIC foods? _____

STAFF USE ONLY	Date: _____ Staff Name: _____
	WIC ID#: _____ Height: _____ Weight: _____

