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

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a. How long do you plan to breastfeed?______________

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b. I breastfeed________times in 24 hours and each feeding lasts________minutes.

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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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?

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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 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!