



# Breastfeeding/Post Partum Women Application

Today's Date \_\_\_\_\_

<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Birth Date</b> 331,332,333
<b>If receiving Medicaid, please provide Medicaid number:</b> _____		<b>or SSN:</b> _____	
<b>Is this person Hispanic or Latino?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Select at least one of the following:</b>	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> White
	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Native Hawaiian/Pacific Islander	

## WIC helps families with healthy food and nutrition choices.

How are you doing after having your baby? Please, tell us if you have any concerns.

\_\_\_\_\_

1. 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: \_\_\_\_\_
2. If you were in the hospital in the last 3 months, please, tell us why. 359  
\_\_\_\_\_
3. Have you been screened or referred for lead poisoning? 211  
 No  Yes
4. Write the date of your last dental check-up \_\_\_\_\_ 381
5. Tell us if 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  
Describe: \_\_\_\_\_
6. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home?  No  Yes 904
7. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping? 801  
 No  Yes
8. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals? 801  
 No  Yes
9. Did a family member have a seasonal farming job with a temporary home in the last 24 months? 802  
 No  Yes
10. Are you in a relationship with anyone who pushes, hits or threatens you in any way?  No  Yes 901
11. What problems, if any, do you have caring for yourself or your baby/children? 902  
Describe: \_\_\_\_\_
12. Circle the type of milk you would like on your WIC checks or in your food box:  
**Fresh Soy      Fluid (UHT) Lactose Reduced 355      Evaporated Dry**
13. What concerns, if any, do you have about having enough food to feed your family?  
Comment: \_\_\_\_\_
14. What was the actual date your baby was born? \_\_\_\_\_
15. What was your baby's length at birth? \_\_\_\_\_
16. What was your baby's weight at birth? \_\_\_\_\_
17. At what Birthing Facility did you give birth? \_\_\_\_\_
18. When did your Prenatal care begin? \_\_\_\_\_
19. **How are you feeding your baby?**  
 Breastmilk     Breastmilk + Formula     Formula Only
20. **If Breastfeeding**, on what date did breastfeeding begin? \_\_\_\_\_
21. On a scale of 0 to 10, how confident are you about breastfeeding your baby? (Circle a number)  
**Not Confident 0 1 2 3 4 5 6 7 8 9 10 Very Confident**  
How long do you plan to breastfeed? \_\_\_\_\_ 601
  - I breastfeed \_\_\_\_\_ times in 24 hours 601,602
  - Each feeding lasts \_\_\_\_\_ minutes 602

### \*\*\*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 \_\_\_\_\_



**If Formula**

Did you ever breastfeed? No Yes

If yes, I breastfed \_\_\_ days or \_\_\_ weeks.

I introduced formula at \_\_\_ weeks.

22. On what date did breastfeeding end? \_\_\_\_\_

23. What is the reason that Breastfeeding was stopped?  
\_\_\_\_\_  
\_\_\_\_\_

24. On a scale of 0 to 10, how well do think you are eating?  
(Circle a number)

**Not Well 0 1 2 3 4 5 6 7 8 9 10 Very Well**

I usually eat \_\_\_ meals /day and \_\_\_ snacks/day.

25. I eat fruits/vegetables: 1 cup/day or less

2 cups/day

3 cups/day or more

26. **Circle if you crave or eat:**

- Ashes                      Baking Soda                      Dust
- Carpet Fibers              Chalk   Cigarettes              Soil
- Clay                          Starch (laundry or corn starch)
- Paint Chips                  Burnt Matches
- Large quantities of ice and/or freezer frost                      427.03

27. List any medication, vitamin, pre-natal vitamins, mineral or herbal supplement you are taking. 357, 427.01  
\_\_\_\_\_  
\_\_\_\_\_

If not daily, how often? \_\_\_\_\_ 427.04

28. Have you fasted, binged or vomited to control your weight or followed a specific diet?  
No Yes 358/427.02

Describe \_\_\_\_\_

29. Do you smoke cigarettes, pipes or cigars?  
No Yes 371

If yes, how much a day \_\_\_\_\_

30. If you smoked in the last three months of your pregnancy, what was your cigarette usage per day?  
\_\_\_\_\_

31. Do you use smokeless, chewing tobacco or iqmik?  
No Yes

How many times per day? \_\_\_\_\_

32. Do you drink wine, beer or other alcoholic beverages?  
No Yes 372

If yes, how many drinks a day? \_\_\_\_\_

If yes, how many days a week? \_\_\_\_\_

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33. If you drank alcohol in the last three months of your pregnancy, what was your alcohol intake?  
\_\_\_\_\_ Drinks/Week

34. **Check any drugs you are using.** 372  
Marijuana Methadone Cocaine  
Crank Crack Methamphetamine Speed  
Heroin Other None Stopped Using  
If stopped using, when was the last time you used?  
\_\_\_\_\_

35. How far apart were your last two pregnancies?  
\_\_\_\_\_ 332

36. How many babies did you have during your last pregnancy? \_\_\_\_\_ 335

37. How many times have you been pregnant? (do not count this pregnancy) \_\_\_\_\_ times

38. How old are your children? \_\_\_ \_\_\_ \_\_\_ \_\_\_ 333

39. **Check if you had any of the problems during your recent pregnancy:**

- Baby born 3 or more weeks early 311
- Baby, less than 5 pounds 9 oz. at birth 312
- Miscarried – how many \_\_\_\_\_ 321
- Baby, 9 pounds or more at birth 337
- Stillbirth – how many \_\_\_\_\_ 321
- Genetic or birth defects 339
- Had more than one baby- how many \_\_\_\_\_ 335
- Baby died before 1 month old 321
- C-Section 359
- History of Gestational Diabetes 303
- History of Preeclampsia 304

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

41. What does your family do for fun?  
\_\_\_\_\_  
\_\_\_\_\_

42. **How can WIC help your family today?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_