Today's Date ___________________

Breastfeeding/Post Partum Women Application

Last Name	First Name	Middle Initial	Birth Date 331,332,333

If receiving Medicaid, please provide Medicaid number: __________________ or SSN:________________________

Is this person Hispanic or Latino? ☐No ☐Yes

Select at least one of the following: ☐American Indian/Alaska Native ☐Asian ☐White ☐Black/African American ☐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? ☐No ☐Yes **211**
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? ☐No ☐Yes **801**
8. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals? ☐No ☐Yes **801**
9. Did a family member have a seasonal farming job with a temporary home in the last 24 months? ☐No ☐Yes **802**
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 **Fluid (UHT)** **Evaporated**
    Soy **Lactose Reduced** **355** **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 ______________________________

Breastfeeding/Post Partum Women Application

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? ________________

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 <u>recent pregnancy</u>**:

☐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?**

____

____

____

Thank You!