



Breastfeeding/Post Partum Women Application

Today's Date _____

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?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Select at least one of the following:	<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? _____

Breastfeeding/Post Partum Women Application

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?**

