|  |  |
| --- | --- |
| **ANTHROPOMETRIC 🞎 WT. GRID PLOTTED**  Height \_\_\_\_\_\_\_\_\_\_\_ Desirable Body Weight\_\_\_\_\_\_\_\_  Weight this Visit \_\_\_\_\_\_\_\_\_\_ Weeks Post-Partum\_\_\_\_\_\_\_\_\_ | Infant Feeding (cont)  12. If you are Bottlefeeding,:  a) how often does your baby get a bottle? \_\_\_\_\_\_\_\_\_\_\_   1. how much does your baby drink at a feeding?\_\_\_\_\_ |
| **BIOCHEMICAL**  **Blood Date Collected:**  Hemoglobin:  **H L**  Hematocrit: **H L**  Glucose:  **H L**  Albumin: **H L**  Blood Pressure: / (circle) GDM PIH | c) ✓ the one(s) you use: 🞎 Concentrated Formula  🞎 Powdered Formula 🞎 Ready to Drink Formula  d) what else do you give your baby? 🞎 Juice 🞎 Cereal  🞎 Sugar Water 🞎 Baby Food 🞎 Other \_\_\_\_\_\_\_ |
| **CLINICAL - Outcome of Pregnancy**  Date of Birth \_\_\_\_\_\_\_\_\_\_\_ Gestational Age \_\_\_\_\_\_\_\_  Birth Weight \_\_\_\_\_\_\_\_\_\_\_ Birth Length \_\_\_\_\_\_\_\_\_\_  Delivery: 🞎 Vaginal 🞎 C-section  Pregnancy Outcome/Complications:  **Maternal**   1. Have you had your post-partum check up? 🞎 Y 🞎 N   If NO, when is it scheduled? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Have you had any problems since delivery: 🞎 Y 🞎 N   If YES, please explain.  **Infant**  3. Has your baby seen the doctor? 🞎 Y 🞎 N  If NO, when is a visit scheduled? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **HEALTH EDUCATION**  13) Do you have any questions about your baby’s care? 🞎 Y 🞎 N  If YES, please explain:  14) Which method of Birth Control are you currently using:  🞎 Birth Control Pills 🞎 Diaphragm 🞎 Condoms  🞎 Norplant 🞎 Depo-Provera(shots) 🞎 Other \_\_\_\_\_\_\_\_\_\_  15) Would you like more information about Birth Control?  16) Do you have an infant safety seat? 🞎 Y 🞎 N  If YES, do you always use it?\_\_\_\_\_\_\_\_\_\_  17) Do you exercise 3 or more times a week? 🞎 Y 🞎 N  18) Do you smoke ? 🞎 Y 🞎 N  If YES, how many cigarettes per day? \_\_\_\_\_\_\_\_\_  19) Do you live with someone who smokes?  20) How often do you drink beer, wine, or liquor? \_\_\_\_\_\_\_\_\_\_\_  21) What drugs have you used since the birth of your baby? |
| **NUTRITION**  **Dietary Assessment 🞎 24 hour recall completed**  4. Are you on a special diet? 🞎 Y 🞎 N  If YES, what diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Are you allergic to any foods, or do you avoid eating any   foods? 🞎 Y 🞎 N  If YES, what foods?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Which of the following do you take:   🞎 Prenatal Vitamins 🞎 Iron Pills  🞎 Other Vitamins/Minerals 🞎 Herbs  🞎 Antacids 🞎 Laxatives 🞎 Other Medications   1. How many cups, glasses, or cans of these do you drink daily? Water \_\_\_\_\_\_\_\_ Milk \_\_\_\_\_\_\_\_\_   Juice \_\_\_\_\_\_\_\_\_\_\_ Coffee \_\_\_\_\_\_\_  Tea \_\_\_\_\_\_\_\_\_\_ Soda \_\_\_\_\_\_\_\_\_\_\_  Diet Soda \_\_\_\_\_\_\_\_\_ Punch/Kool Aid \_\_\_\_\_\_\_\_\_\_\_   1. How many times a day do you usually eat? \_\_\_\_\_\_\_ 2. Which of the following do you have?   🞎 Refrigerator 🞎 Stove/Oven 🞎 Hot Plate | **PSYCHOSOCIAL**  22) Since your baby’s birth, which of the following have you had?  🞎 trouble sleeping 🞎 sadness 🞎 worried feelings  🞎 crying 🞎 depression 🞎 sadness 🞎 none  🞎 other\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. If you are worried about something, who do you talk to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Are you and your baby are safe in your home? 🞎 Y 🞎 N   25) Have you ever planned or tried to hurt yourself? 🞎 Y 🞎 N  26) Have you ever planned or tried to hurt someone? 🞎 Y 🞎 N  27) Since the birth of your baby, have you been slapped, hit, kicked  or otherwise physically hurt by someone? 🞎 Y 🞎 N  If YES, by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  28) Do you have: 🞎 electricity 🞎 hot water 🞎 telephone  🞎 transportation 🞎 heating  29) Are you able to buy enough food? 🞎 Y 🞎 N  30) Are you able to pay your rent? 🞎 Y 🞎 N  31) Are you able to pay your other bills? 🞎 Y 🞎 N |
| Infant Feeding  10. How many diapers does your baby wet in a day? \_\_\_\_\_\_  11. If you are Breastfeeding:  a) how many times in 24 hours do you nurse? \_\_\_\_\_\_\_\_  b) how long does your baby nurse each time? \_\_\_\_\_\_\_\_ | 🞎 WIC Referral Date enrolled \_\_\_\_\_\_\_\_\_\_  Appointment Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other Referrals**:**   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_   Materials Given**:**  🞎 Family Planning 🞎 Infant Feeding  🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |