

Name: _____ Today's date: _____
Weight: _____ Height: _____ Total prenatal weight gain : _____ Delivery date: _____

Please answer these questions.

1. Please describe your labor and delivery.

2. How would you describe your health?

3. For the pregnancy just completed, how many babies did you have? _____

4. Did you have a cesarean delivery?
 Yes No

5. Was your baby born early?
 Yes, born less than or equal to 37 weeks.
 No, born after 37 weeks.

6. What was your baby's birth weight? _____ Pounds _____ Ounces

OVER ⇨

7. Do you have any medical or health problems?

Yes (please describe) _____

No

8. Do you take any medications?

Yes (please list) _____

No

9. Do you smoke cigarettes now?

Yes. How many per day? _____

No

10. Does anyone living in your household smoke inside the house?

Yes No

11. Do you routinely drink two or more servings of beer, wine or hard liquor per day?

Yes No

12. Have you used any drugs since delivery?

Yes No

For alternate format requests, please call 971-673-0040. TTY 1-800-735-2900

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