


Postpartum Diet Questionnaire

Your Name: _____ Birth Date: ___/___/___ Today's date: ___/___/___

- Please check all of the following you have that work. Stove Top Oven Microwave Refrigerator
- How many times do you eat each day? Meals _____ Snacks _____
- Are there any foods or beverages that you cannot or will not eat? No Yes, please list _____
- Are there any foods of which you think you do not eat enough? No Yes, please list _____
- What do you usually drink? (Please check all that apply.) Milk Water Juice/Juice Drinks
 Gatorade/Sports Drinks Wine/Beer/Alcoholic Drinks Coffee/Tea Herbal Teas Hot chocolate
 Regular Pop/Kool-Aid Diet Pop Other: _____
- How often do you drink milk? Several times/day Once/day Less than once/day Do not drink milk
What type of milk do you usually drink? Cow's(____ Whole (Vitamin D) _____ Reduced/Low Fat (2%, 1% or ½%) _____ Skim)
 Lactose Free Evaporated Sweetened Condensed Soy Rice Goat's
 Raw (Cow's or Goat's) Other: _____
- How many times do you eat fruits and vegetables during a normal day? _____ Do not eat any fruits or vegetables
Which fruits and/or vegetables (not juice) do you usually eat? (Please check all that apply.) Bananas Grapes
 Apples/Applesauce Oranges Pears Carrots Green Beans Potatoes French Fries
 Corn Sprouts Tomato Other: _____
- Which protein foods do you usually eat? (Please check all that apply.) Beef/Buffalo Chicken/Turkey Fish/Seafood
 Pork/Lamb Hot Dogs/Lunch Meat Meat Spreads/Pâté Dried Beans Eggs Tofu Yogurt
 Soft Cheese (Feta, Brie, Blue-Veined, and Queso Fresco) Hard Cheese (American, Cheddar, Swiss...)
 Other _____
How many times do you eat protein foods during a normal day? _____
- Do you ever eat anything that is not food, such as ashes, chalk, clay, dirt, large quantities of ice, or starch (laundry or cornstarch)? No Yes
- Are you on a special diet or trying to lose weight? No Yes, please describe _____
- Do you have any medical/health/dental problems? No Yes, please list _____
Was this problem diagnosed by a doctor / dentist? No Yes
- Please check and describe all of the following you routinely use. (All information given to the WIC Program is confidential.)
 Over-the-counter drugs (laxatives, pain killers, etc.) _____
 Prescription medication _____
 Vitamin and/or minerals supplements _____
 Herbs/Herbal Supplements (Echinacea, ginger, etc.) _____
 Tobacco Street drugs (Marijuana, cocaine, methamphetamines, etc.) Other: _____
- Have you had a blood lead test? No Unsure Yes, where? _____
- How much did you weigh before your pregnancy that just ended? _____
- Please check any of the following that are true about your pregnancy that just ended.
 My baby was born more than 3 weeks early My baby was born weighing less than 5 pounds 9 ounces
 My baby was born weighing 9 pounds or more My baby was born with a birth defect
 My doctor told me I had gestational diabetes My doctor told me I had pregnancy induced hypertension
 I had a C-Section I had more than one baby (twins, triplets, etc.)
 I had no complications Other, please list _____
- Not including this last time, how many times have you been pregnant? _____
When did your last (not this) pregnancy end? ___/___/___ This was my first pregnancy
- Have you breastfed your baby at any time since the delivery Yes, currently breastfeeding Yes, but not now No
(If you are not currently breastfeeding stop here) 
- What do you think about breastfeeding? _____
- Are you experiencing any of the following situations? (Check all that apply.)
 Baby always seems to be hungry Don't have enough milk Baby refuses breast, arches back
 Sore nipples Sore breasts Engorged or full, hard breasts Other _____