Prenatal Diet Questionnaire

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

1. Please check all of the following you have that work. ☐Stove Top ☐Oven ☐Microwave ☐Refrigerator

2. How many times do you eat each day? Meals _____ Snacks _____

3. Are there any foods or beverages that you cannot or will not eat? ☐No ☐Yes, please list _______________________________

4. Are there any foods of which you think you do not eat enough? ☐No ☐Yes, please list _______________________________

5. 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:____

6. 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:____

7. 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:____

8. How many times do you eat protein foods during a normal day? __________ ☐Do not eat protein foods

9. 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 ____

10. Do you ever eat anything that is not food, such as ashes, chalk, clay, dirt, large quantities of ice, or starch (laundry/cornstarch)? ☐No ☐Yes

11. Are you on a special diet? ☐No ☐Yes, please describe ____

12. How much weight do you think you should gain with this pregnancy? ______________ pounds

13. Have you seen a doctor for this pregnancy? ☐No ☐Yes, date of your first visit? ___/___/______ # of visits ____________

14. Are you expecting twins, triplets, etc? ☐No ☐Yes

15. Are you having any problems/complications with this pregnancy? ☐Heartburn ☐Nausea and vomiting ☐Gestational diabetes
    ☐High blood pressure ☐Constipation ☐Diarrhea ☐Weight loss ☐Other, please describe ______________

16. Do you have any medical/health/dental problems? ☐No ☐Yes, please list _______________________________
    Was this problem diagnosed by a doctor / dentist? ☐No ☐Yes

17. 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:_______________________

18. Have you had a blood lead test? ☐No ☐Unsure ☐Yes, where? _______________________________

19. Not including this time, how many times have you been pregnant? ______________ **(If this is your first pregnancy stop here)**
    - When did your last pregnancy end? ___/___/______
    - Are you currently breastfeeding a baby/child? ☐No ☐Yes
    - Please check any of the following that were true with any of your previous pregnancies.

    ☐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 ☐I have had no complications
    ☐Other, please list ____

10/2007