

Your name: _____ Today's date: _____

Please answer these questions.

1. What changes have you made to your eating habits since becoming pregnant or having your baby?
2. Thinking about a typical day, what meals, snacks and beverages would you have?
3. How do you feel about the weight changes that you have experienced?
4. Do you have any of the following discomforts?
 Nausea Vomiting Other: _____
 Constipation Poor appetite _____
 Heartburn None of these
5. What foods, if any, do you avoid for health or other reasons?
6. Are you on a low-calorie or restricted diet?
 Yes (please describe) _____
 No

OVER ⇨

7. Do you eat anything that is not food?

Yes (please list) _____

No

8. Do you eat raw or undercooked meat, poultry, fish or eggs or use unpasteurized dairy products or juice?

9. What vitamins or supplements do you take? Check all that apply:

Prenatal vitamin

Multi-vitamin

Multi-vitamin with iron

Iron

Folic acid

None

Other: _____

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

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