Ohio Department of Health | OHIO WIC Women, Infants, and Children Program | Grow Together Breastfeed

Complete frontside ONLY

Maternal Health Assessment

Date(s): _____ **Name:** _____ **Age:** _____

Maternal Health History Questions *(please complete all questions on this side – leave the backside blank)*

Where do you go for prenatal/postpartum care? Doctor/clinic name: _____

Check all pregnancy and delivery related conditions you have or had in the past:

☐ Gestational diabetes ☐ High blood pressure ☐ Pregnancy loss ☐ Early baby (less than 39 weeks)

☐ Small baby (5 pounds 8 ounces, or less) ☐ Large baby (9 pounds or more) ☐ Baby born with a health problem

☐ Other: _____ ☐ N/A

Do you have any medical conditions, illness, food allergies, or a recent surgery or injury? Please describe:

_____ ☐ N/A

Please list medications or herbs you take: _____ ☐ N/A

Do you or your dentist have any dental concerns? ☐ Yes _____ ☐ No ☐ I don't have a dentist

Has anyone in your family been tested for lead? ☐ Yes (levels): _____ ☐ No ☐ I don't know

Have you been/are you being treated for depression or other mental health concerns? ☐ Yes ☐ No

Over the past two weeks, how often have you been bothered by any of the following problems?

- **Little interest or pleasure in doing things:**
  ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
- **Feeling down, depressed, or hopeless:**
  ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Do you live in a temporary place (shelter, hotel, etc.)? ☐ Yes ☐ No

Have you been physically, verbally, sexually abused, or neglected? ☐ Yes ☐ No

Are there times when anyone makes you feel unsafe? ☐ Yes ☐ No

Do you have a safe place to go? ☐ Yes ☐ No

Do you worry about running out of food? ☐ Yes ☐ No

Do you use local food banks/pantries? ☐ Yes ☐ No

What questions or concerns do you have about your health, eating habits, and breastfeeding? _____

_____

This portion is to be completed by WIC staff

☐ **New Cert (*date*):** _____ ☐ **Recert (*date*):** _____ ☐ **HA (*date*):** _____ ☐ **Continue Goal**

Location of WIC Program Application: _____

HT _____ **WT** _____ **Hgb** _____ (optional)

Nutrition, Breastfeeding, and Physical Activity Questions *(to be completed by WIC staff member)*

What does screen time look like for you? Time/day _____ Days/week _____

Tell me about the physical activities you enjoy: _____ Time/day _____ Days/week _____

Briefly describe what you eat and drink each day: _____

_____

Targeted diet assessment <u>may</u> include:

- Vitamins, iron sources, enhancers, inhibitors
- Dairy/calcium/vitamin D
- Iodine/folic acid
- Whole grains/fiber
- Protein sources
- Fruits and vegetables
- Sugar sweetened drinks/foods
- Foods limited/refused/avoided
- Unsafe foods (including non-food items)
- Meals away from home/fast food
- Working kitchen appliances
- Religious or cultural diets
- Water source

Caregiver with limited feeding decision/inability to prepare foods:

☐ Current/history of alcohol or substance abuse ☐ Mental illness, including severe depression

☐ Intellectual disability ☐ Physical disability ☐ Age ≤ 17 years ☐ N/A

(P) What do you know about breastfeeding or giving breast milk to your baby? _____

_____

(P) Breastfeeding intention: ☐ Yes ☐ No ☐ Maybe

(B) Tell me about your experience offering breast milk to your baby so far: _____

_____

Targeted breastfeeding assessment <u>may</u> include:

- Knowledge of appropriate feeding frequency and amount
- Latch difficulties
- Engorgement
- Pain or discomfort of breasts and/or nipples
- Pump needs/questions
- Referrals or follow ups needed

(B) What is your goal for breastfeeding or giving breastmilk to your baby? _____

_____

Notes: