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| **ANTHROPOMETRIC 🞎 WT. GRID PLOTTED**Height \_\_\_\_\_\_\_\_\_\_\_ Desirable Body Weight\_\_\_\_\_\_\_\_Weight this Visit \_\_\_\_\_\_\_\_\_\_ Weeks Post-Partum\_\_\_\_\_\_\_\_\_ | Infant Feeding (cont)12. If you are Bottlefeeding,:a) how often does your baby get a bottle? \_\_\_\_\_\_\_\_\_\_\_1. how much does your baby drink at a feeding?\_\_\_\_\_
 |
| **BIOCHEMICAL****Blood Date Collected:**Hemoglobin:  **H L**  Hematocrit: **H L**Glucose:  **H L**  Albumin: **H L**Blood Pressure: / (circle) GDM PIH |  c) ✓ the one(s) you use: 🞎 Concentrated Formula  🞎 Powdered Formula 🞎 Ready to Drink Formula d) what else do you give your baby? 🞎 Juice 🞎 Cereal 🞎 Sugar Water 🞎 Baby Food 🞎 Other \_\_\_\_\_\_\_ |
| **CLINICAL - Outcome of Pregnancy**Date of Birth \_\_\_\_\_\_\_\_\_\_\_ Gestational Age \_\_\_\_\_\_\_\_Birth Weight \_\_\_\_\_\_\_\_\_\_\_ Birth Length \_\_\_\_\_\_\_\_\_\_Delivery: 🞎 Vaginal 🞎 C-sectionPregnancy Outcome/Complications:**Maternal**1. Have you had your post-partum check up? 🞎 Y 🞎 N

 If NO, when is it scheduled? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Have you had any problems since delivery: 🞎 Y 🞎 N

 If YES, please explain.**Infant**3. Has your baby seen the doctor? 🞎 Y 🞎 N If NO, when is a visit scheduled? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **HEALTH EDUCATION**13) Do you have any questions about your baby’s care? 🞎 Y 🞎 N If YES, please explain:14) Which method of Birth Control are you currently using: 🞎 Birth Control Pills 🞎 Diaphragm 🞎 Condoms  🞎 Norplant 🞎 Depo-Provera(shots) 🞎 Other \_\_\_\_\_\_\_\_\_\_15) Would you like more information about Birth Control? 16) Do you have an infant safety seat? 🞎 Y 🞎 N If YES, do you always use it?\_\_\_\_\_\_\_\_\_\_17) Do you exercise 3 or more times a week? 🞎 Y 🞎 N18) Do you smoke ? 🞎 Y 🞎 N  If YES, how many cigarettes per day? \_\_\_\_\_\_\_\_\_19) Do you live with someone who smokes?20) How often do you drink beer, wine, or liquor? \_\_\_\_\_\_\_\_\_\_\_21) What drugs have you used since the birth of your baby? |
| **NUTRITION****Dietary Assessment 🞎 24 hour recall completed**4. Are you on a special diet? 🞎 Y 🞎 N If YES, what diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Are you allergic to any foods, or do you avoid eating any

 foods? 🞎 Y 🞎 N  If YES, what foods?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Which of the following do you take:

 🞎 Prenatal Vitamins 🞎 Iron Pills  🞎 Other Vitamins/Minerals 🞎 Herbs 🞎 Antacids 🞎 Laxatives 🞎 Other Medications1. How many cups, glasses, or cans of these do you drink daily? Water \_\_\_\_\_\_\_\_ Milk \_\_\_\_\_\_\_\_\_

 Juice \_\_\_\_\_\_\_\_\_\_\_ Coffee \_\_\_\_\_\_\_  Tea \_\_\_\_\_\_\_\_\_\_ Soda \_\_\_\_\_\_\_\_\_\_\_ Diet Soda \_\_\_\_\_\_\_\_\_ Punch/Kool Aid \_\_\_\_\_\_\_\_\_\_\_1. How many times a day do you usually eat? \_\_\_\_\_\_\_
2. Which of the following do you have?

 🞎 Refrigerator 🞎 Stove/Oven 🞎 Hot Plate | **PSYCHOSOCIAL**22) Since your baby’s birth, which of the following have you had? 🞎 trouble sleeping 🞎 sadness 🞎 worried feelings  🞎 crying 🞎 depression 🞎 sadness 🞎 none 🞎 other\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. If you are worried about something, who do you talk to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you and your baby are safe in your home? 🞎 Y 🞎 N

25) Have you ever planned or tried to hurt yourself? 🞎 Y 🞎 N26) Have you ever planned or tried to hurt someone? 🞎 Y 🞎 N27) Since the birth of your baby, have you been slapped, hit, kicked  or otherwise physically hurt by someone? 🞎 Y 🞎 N  If YES, by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_28) Do you have: 🞎 electricity 🞎 hot water 🞎 telephone 🞎 transportation 🞎 heating 29) Are you able to buy enough food? 🞎 Y 🞎 N30) Are you able to pay your rent? 🞎 Y 🞎 N31) Are you able to pay your other bills? 🞎 Y 🞎 N |
| Infant Feeding10. How many diapers does your baby wet in a day? \_\_\_\_\_\_11. If you are Breastfeeding: a) how many times in 24 hours do you nurse? \_\_\_\_\_\_\_\_ b) how long does your baby nurse each time? \_\_\_\_\_\_\_\_ |  🞎 WIC Referral Date enrolled \_\_\_\_\_\_\_\_\_\_ Appointment Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other Referrals**:**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

Materials Given**:** 🞎 Family Planning 🞎 Infant Feeding 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |