

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/Canned 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 _____