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 institution is an equal opportunity provider.