

Postpartum 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 1/2%) _____ 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. 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 _____
How many times do you eat protein foods during a normal day? _____

9. Do you ever eat anything that is not food, such as ashes, chalk, clay, dirt, large quantities of ice, or starch (laundry or cornstarch)? No Yes

10. Are you on a special diet or trying to lose weight? No Yes, please describe _____

11. Do you have any medical/health/dental problems? No Yes, please list _____
Was this problem diagnosed by a doctor / dentist? No Yes

12. 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: _____

13. Have you had a blood lead test? No Unsure Yes, where? _____

14. How much did you weigh before your pregnancy that just ended? _____