


# 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, please list \_\_\_\_\_
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 \_\_\_\_\_