Manual Certification – Women

UPDATED DECEMBER 2022

Date:

State WIC ID: WIC Type: ☐ Pregnant ☐ Breastfeeding ☐ non-Breastfeeding

Certification Type: ☐ New Certification ☐ Re-Certification ☐ Mid-Certification

Demographics Information

Last Name: First Name: Birth Date: (mm/dd/yyyy)

Hispanic or Latino Ethnicity: ☐ Yes ☐ No

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native

If American Indian/Alaska Native, please select one of the following:

☐ Bois Forte ☐ Fond du Lac ☐ Grand Portage ☐ Leech Lake ☐ Lower Sioux ☐ Upper Sioux ☐ White Earth

☐ Mille Lacs Tribe ☐ Red Lake ☐ Mdewakanton ☐ Prairie Island ☐ Other ☐ Participant Declined

Insurance Type: ☐ MA ☐ MN Care ☐ None ☐ Other ☐ Private
Medical Clinic:
Household language:
Authorized Representative/Primary Card Holder: Alternate Representative/Proxy 1: Alternate Representative/Proxy 2:

Health Information – Pregnant

Current Pregnancy Information

☐ Expected Multiple Births ☐ Planned C-section ☐ Diabetes Mellitus ☐ Gestational Diabetes ☐ Hypertension or Prehypertension

Expected Delivery: (mm/dd/yyyy) _____ LMP Start Date: (mm/dd/yyyy) _____ Pre-pregnancy Weight: _____

☐ Has Not Received Prenatal Care Date Prenatal Care Began: (mm/yyyy): _____

☐ Required Food Package III Date Food Package III Verified: (mm/dd/yyyy): _____

☐ Currently Breastfeeding Infant Breastfeeding Amount: _____

☐ Currently Breastfeeding Child Over 1 Date Breastfeeding Verified: (mm/dd/yyyy) _____

Previous Pregnancy Information

Number of Pregnancies: _____ Number of Live Births: _____ Number of WIC Pregnancies: _____

Number of Pregnancies 20 or more Weeks: _____ Last Pregnancy Ended: (mm/yyyy) _____ ☐ Live Birth within 18 Months

Multivitamin Consumption

How often the month prior to pregnancy? _____ How often during Pregnancy? _____

Cigarette Usage

Number Per Day - 3 months prior to pregnancy: _____ Number Per Day - Current: _____

Smoking Change: _____ Household Smoking: ☐ Yes ☐ No

Alcohol Intake

Drinks/Week - 3 months prior to pregnancy: _____ Drinks/Week - Current: _____

Any Pregnancy History

☐ Low Birth Weight ☐ Preterm or Early Term Delivery ☐ Gestational Diabetes ☐ Preeclampsia

☐ Fetal or Neonatal Loss or 2 or more Spontaneous Abortions

Health Information – Postpartum

Postpartum Information

Expected Delivery: (mm/dd/yyyy) _____ LMP Start Date: (mm/dd/yyyy) _____

Actual Delivery Date (mm/dd/yyyy): _____ Hospital Discharge Date: (mm/dd/yyyy) _____

Weight Gain during Pregnancy: _____ Weight at Delivery: _____

☐ C-section Delivery ☐ Diabetes Mellitus ☐ Hypertension or Prehypertension ☐ On WIC During Most Recent Pregnancy

☐ Required Food Package III Date Food Package III Verified: (mm/dd/yyyy) _____

☐ Did not Receive Prenatal Care Date Prenatal Care Began: (mm/yyyy) _____

Previous Pregnancy Information

Number of Pregnancies: _____ Number of Live Births: _____ Number of WIC Pregnancies: _____

Number of Pregnancies 20 or more Weeks: _____ Last Pregnancy Ended: (mm/yyyy) ☐ Live Birth within 18 Months

Multivitamin Consumption

How often the month prior to pregnancy? _____ How often during Pregnancy? _____

Cigarette Usage

Number Per Day - 3 months prior to pregnancy: _____ Number Per Day – Current: _____

Smoking Change: _____ Household Smoking: ☐ Yes ☐ No

Alcohol Intake

Drinks/Week - 3 months prior to pregnancy: _____ Drinks/Week – Current: _____

Most Recent Pregnancy History

☐ Low Birth Weight ☐ Preterm or Early Term Delivery ☐ Muti-fetal Gestation

☐ Fetal or Neonatal Loss or 2 or more Spontaneous Abortions

Any History Of

☐ Gestational Diabetes ☐ Preeclampsia ☐ Live Birth within 18 months

Infant(s) Born from This Pregnancy (Gather information for each infant if multiples)

Status at Birth

☐ Live at Postpartum Visit ☐ Not Alive at Postpartum Visit ☐ Stillborn, Miscarriage, or Abortion ☐ Neonatal Death (live 0-28 days)

☐ Infant in Foster Care ☐ Infant on WIC

State WIC ID: _____ Name: _____ Gender: ☐ Male ☐ Female

Birth Length: _____ Birth Weight: _____

Breastfeeding Information

Ever Breastfed: ☐ Yes ☐ No ☐ Unknown

Breastfeeding Now: ☐ Yes ☐ No

If **Yes**, Breastfeeding Amount: _____ Date Breastfeeding Verified: (mm/dd/yyyy): _____

If **No**, Reason(s) Stopped: _____

Date Breastfeeding Began: (mm/dd/yyyy): _____ Date Breastfeeding ended: (mm/dd/yyyy): _____

If not fully breastfeeding, Date Supplemental Feeding Began: (mm/dd/yyyyy) _____ ☐ Not Applicable

If solids were introduced, Date Began: (mm/dd/yyyy) _____ ☐ Not Applicable

Height Weight and Blood

Measurement Date: _____ Length/Height: _____inches _____1/8th Weight:_____ lbs _____ ounces

Date for Blood work: _____ Hgb:_____ HCT:_____

Reason Blood Work not Collected (write note): _____

☐ CPA determined not due ☐ Medical ☐ Religious

Nutrition Assessment

Results:

Nutrition Education/Materials Given

NE topics and Materials Given:

Referrals

Referrals Given:

Food Package

Notes:

Comments

Notes:

Minnesota Department of Health - WIC Program 85 E 7th Place, PO BOX 64882, ST PAUL MN 55164-0882; 1-800-657-3942, health.wic@state.mn.us, www.health.state.mn.us; To obtain this information in a different format, call: 1-800-657-3942