DIETARY QUESTIONNAIRE FOR WOMEN
Pennsylvania Department of Health -- WIC Program

Endorser's Name: _____ D.O.B.: _____ F.I.D. #: _____ Date: _____

Please fill in the blanks and check all answers that apply.

1. **Do you have any medical problems?** ☐ No ☐ Yes **Dental problems or cavities?** ☐ No ☐ Yes
   Please list or describe: _____
   Do you take any medicine? ☐ No ☐ Yes
   Please list: _____

   Do you have any problems with your current pregnancy? ☐ No ☐ Yes ☐ Not applicable
   Please list or describe: _____
   Have you ever had problems with a previous pregnancy or delivery? ☐ No ☐ Yes
   Please list or describe: _____
   In the past few weeks, have you been feeling down or depressed, or lost interest in doing things you enjoy? ☐ No ☐ Yes

2. **Do you have frequent problems with any of the following?**
   ☐ Nausea ☐ Vomitting ☐ Diarrhea ☐ Heartburn ☐ Chewing food ☐ Poor appetite ☐ Gas ☐ Cramps
   ☐ Constipation ☐ None of these

3. **Are you on a special diet such as Vegetarian, Low Carbohydrate, or Macrobiotic?**
   ☐ No ☐ Yes **If yes, describe:** _____
   Do you feel you need to cut down on any of the following? ☐ No ☐ Yes If yes, which ones?
   ☐ Sugar ☐ Calories ☐ Salt ☐ Fat ☐ Carbohydrate ☐ Other _____

4. **Do you take any of these?** ☐ No ☐ Yes **If yes, which ones?**
   ☐ Prenatal Vitamin ☐ Multivitamin ☐ Folic Acid ☐ Vitamin D ☐ Iron ☐ Iodine ☐ Herbal teas/supplements
   ☐ Other _____

5. **Do you crave or eat any of the following?** ☐ No ☐ Yes **If yes, which ones?**
   ☐ Laundry starch ☐ Soil ☐ Chalk ☐ Paint chips ☐ Cigarette ashes ☐ Ice (in large quantities)
   ☐ Burnt matches ☐ Clay ☐ Carpet fibers ☐ Cornstarch ☐ Other _____

6. **Do you eat any of these foods?**
   ☐ Raw cookie dough or cake batter ☐ Hot dogs, deli or lunch meats ☐ Bean sprouts
   ☐ Raw or undercooked eggs, meat, or fish ☐ Soft cheeses like feta or brie
   ☐ Milk, juice, or cider from a mill or farm (if unpasteurized)

7. **Check which items you have at home that work:**
   ☐ Running water ☐ Stove ☐ Refrigerator ☐ Freezer ☐ Microwave

   Do you have a thermometer in the refrigerator or freezer? ☐ No ☐ Yes
   If yes, what is the refrigerator temperature? _____ **Freezer temperature?** _____

8. **Describe how you defrost froods:** ☐ Under running water ☐ In the refrigerator ☐ On the counter ☐ In the microwave

   Does everyone wash their hands before and after food preparation? ☐ No ☐ Yes
   Are different cutting boards used for fruits/vegetables and raw meats? ☐ No ☐ Yes

9. **Check how often you eat the foods listed below:**

Meats, chicken, fish:	☐ Daily	☐ Some days	☐ Never
Grains (pasta, rice, bread, cereal, tortilla):	☐ Daily	☐ Some days	☐ Never
Fruits:	☐ Daily	☐ Some days	☐ Never
Eggs:	☐ Daily	☐ Some days	☐ Never
Vegetables:	☐ Daily	☐ Some days	☐ Never
Peanut butter:	☐ Daily	☐ Some days	☐ Never
Cheese:	☐ Daily	☐ Some days	☐ Never
Beans (pinto, kidney, etc.):	☐ Daily	☐ Some days	☐ Never

10. **How many meals do you eat each day?** ☐ 1 ☐ 2 ☐ 3 or more
How many times a day do you eat snacks? ☐ 1 ☐ 2 ☐ 3 or more ☐ None
Check the foods that you eat for snacks:
☐ Cookies ☐ Crackers ☐ Chips ☐ Pretzels ☐ Cereal ☐ Cereal bars ☐ Cheeses
☐ Yogurt ☐ Fruit ☐ Pudding ☐ Vegetables ☐ Candy ☐ Other _____

11. **Are you allergic to any foods?** ☐ No ☐ Yes
Which foods? ☐ Fish/Seafood ☐ Peanuts/Nuts ☐ Eggs ☐ Wheat
☐ Soy ☐ Milk/dairy products ☐ Other _____

12. **How much milk do you drink each day?** ☐ Less than 1 cup ☐ 1 to 2 cups ☐ 3 or more cups ☐ Do not drink milk
Check what kinds of milk you drink:
Cow's milk: ☐ Whole ☐ 2% ☐ 1% ☐ Skim ☐ Lactose-free ☐ Chocolate/Strawberry
☐ Goat's milk ☐ Soy milk ☐ Almond milk ☐ Rice milk ☐ Other _____

13. **Check what beverages you drink:**
☐ Soda or pop ☐ Kool-Aid ☐ 100% fruit juice ☐ Drinks in boxes, pouches, etc.
☐ Juice drinks (Hawaiian Punch, Hi-C, Sunny D, etc.) ☐ Tea ☐ Gatorade
☐ Energy drinks ☐ Coffee ☐ Water ☐ None of these ☐ Other _____

14. **How often do you eat at fast food places such as Burger King or McDonalds?**
☐ Every day ☐ A few times a week ☐ Once a week ☐ Once a month or less often

15. **Other than work, how many hours per day do you watch TV or use the computer or the cell phone?**
☐ 1 or less ☐ 2 ☐ 3 ☐ 4 or more

16. **How often do you get 30 minutes or more of physical activity (walking, running, playing with kids, etc.)?**
☐ Every day ☐ 3-5 days per week ☐ Once per week ☐ Seldom

17. **Do you have a family history of weight problems?** ☐ No ☐ Yes

18. **Do you use any of the following?** ☐ No ☐ Yes
Cigarettes How many per day? _____
Alcohol (Beer, Wine, Liquor) How much per day? _____
Street Drugs: What kinds and how often? _____
Do you have a history of drug or alcohol abuse? _____

19. **Does anyone smoke in your home?** ☐ No ☐ Yes

20. **Do you ever have to choose between buying food and paying bills?** ☐ A lot ☐ Sometimes ☐ Rarely ☐ Never

21. **What questions do you have about nutrition or your diet?** _____

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