DEPARTMENT OF HEALTH

MINNESOTA WIC

Manual Certification – Women

FEBURARY 2023

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): ____________________ Gender: ☐ Male ☐ Female

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 Melitus ☐ 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 Melitus ☐ 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 625 Robert St N, PO BOX 64975, ST PAUL MN 55164-0975;
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*

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