



Rhode Island Department of Health WIC Program



Medical information Form for Pregnant Women

The healthcare provider should print out this form, complete it, and give it back to the patient.
The patient should return the completed form to their local WIC agency.

A. Patient Information	
Name:	Date of birth:
Date of 1 st prenatal visit:	EDD:
PGW:	Gravida _____ Para _____
Weight at 1 st prenatal visit:	# previous pregnancies > 20 weeks or more _____
Date last pregnancy ended (mm/yyyy):	
Please list all medications and supplements prescribed:	
B. Current Pregnancy Information	
Measurement date:	Lab result date*:
Weight:	Hgb* or Hct*:
Height:	<i>*Must be collected 4-6 weeks after delivery</i>
C. Please Indicate any Medical Conditions with Current Pregnancy	
<input type="checkbox"/> Gestational diabetes <input type="checkbox"/> Expecting multiples <input type="checkbox"/> Closely spaced pregnancies premature birth	<input type="checkbox"/> Preeclampsia <input type="checkbox"/> Low maternal weight gain <input type="checkbox"/> High maternal weight gain
D. Other Health/Medical Concerns (Please describe)	
E. Please Indicate any Medical Conditions with Previous Pregnancies	
<input type="checkbox"/> LBW <input type="checkbox"/> Premature Birth <input type="checkbox"/> History of Fetal or Neonatal Loss	<input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Preeclampsia <input type="checkbox"/> Other: _____
F. Patient's Healthcare Provider	
Provider Name:	
Signature:	Date:
Address:	Phone: