WIC Information Form

This form is to be used to provide health and medical information to the WIC Program.
Please complete the following:

Patient's Name ______________________________ **Birth Date** ____________________________

Sex: M or F (circle one) **Date of Collection** ____________________

Child (Birth to 5 Years)	**Woman**
Birth Weight: _______ lbs. _______ oz. Birth Length: _______ in. Present Weight: _______ lbs. _______ oz. Present Length: _______ in. Present Height: _______ ft. _______ in.	Height: _______ ft. _______ in. Prepregnancy Weight: _______ lbs. _______ oz. Present Weight: _______ lbs. _______ oz. Weight at Labor: _______ lbs. _______ oz. Total Pregnancy Weight Gain: _______ lbs.
*Hemoglobin: _______ g/dl *Hematocrit: _______ % Hematological test contraindicated ☐ yes ☐ no If yes, related medical condition: Is the condition treatable ☐ yes ☐ no Is the condition lifelong ☐ yes ☐ no	Hemoglobin: _______ g/dl Hematocrit: _______ % Hematological test contraindicated ☐ yes ☐ no If yes, related medical condition: Is the condition treatable ☐ yes ☐ no Is the condition lifelong ☐ yes ☐ no
Current Medical Conditions:	Estimated Due Date: ______________________________ Actual Delivery Date: ______________________________ Current Medical Conditions:

*Not required under 9 months of age.

Additional Information:

Please Print: Health Professional's Name/Title ____

Address ____

Phone ____

Signature ____________________________________ Date ____

This institution is an equal opportunity provider.