Rhode Island Department of Health WIC Program
Medical Information Form for Pregnant Women

Note to Health Care Provider:
Please print out this form, complete it and give it back to your patient to return to WIC

A. Patient Information	
Name:	Date of Birth:
Date of 1st Prenatal Visit:	EDD:
PGW:	Gravida _____ Para _____
Weight at 1st Prenatal Visit:	# previous pregnancies > 20 weeks or more _____
Date last pregnancy ended (month/year):	
Please list all medications **and** supplements prescribed:	

B. Current Pregnancy Information	
Measurement Date:	Lab Result Date:
Weight:	*Hgb (gm/dl) or *Hct (%):
Height:	*Must be obtained during current pregnancy

C. Please Indicate any Medical Conditions with **Current** Pregnancy	
☐ Gestational Diabetes	☐ Preeclampsia
☐ Expecting Multiples	☐ Low Maternal Weight Gain
☐ Closely Spaced Pregnancies	☐ High Maternal Weight Gain

D. Other Health/Medical Concerns (Please describe)

E. Please Indicate any Medical Conditions with **Previous** Pregnancies	
☐ LBW	☐ Gestational Diabetes
☐ Premature Birth	☐ Preeclampsia
☐ History of Fetal or Neonatal Loss	☐ Other: _____

F. Patient's Health Care Provider	
Provider Name:	
Signature:	Date:
Address:	Phone: