



**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:
EDD:	
PGW:	
Date of 1 st Prenatal Visit:	
Expecting Multiple Births: Yes ___ No ___	

B. Current Pregnancy Information	
Date Completed:	Date Collected:
Weight:	*Hgb:
Height:	*Hct:
*Must be during current pregnancy	

C. Health/Medical Concerns (including ICD-9 code (s))

D. Previous Pregnancy Information
Number of Previous Pregnancies:
Number of Previous Pregnancies 20 wks or more:
Number of Live Births:
Last Pregnancy Ended: (Month/Year)
Any History of the Following: <input type="checkbox"/> LBW <input type="checkbox"/> Premature Birth <input type="checkbox"/> History of Fetal or Neonatal Loss

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