INFANT HEALTH AND DIET QUESTIONS
(Birth through 1 year of age)
Michigan Department of Health and Human Services

Today's date

Your baby's name

Your baby's birth date:  
Month/Day/Year__________  Boy ☐  Girl ☐

The following question is optional. Your answer will be used for reporting purposes. If you do not answer, the staff will make a selection for you. This does not affect you receiving WIC benefits.

Is your baby Hispanic or Latino?  Is your baby Arabic?  Check all races that apply to your baby:
☐ Yes ☐ No  ☐ Yes ☐ No  
☐ American Indian or Alaska Native  ☐ Asian  ☐ Black or African American  ☐ Native Hawaiian or Other Pacific Islander  ☐ White

What was your baby's birth weight?  [_____ pounds  _____ ounces]
What was your baby's birth length?  [_____ inches]

When was your baby born?  What was your due date?
Month/Day/Year__________________  Month/Day/Year__________________

Note to Staff: Calculate Weeks gestation with client's response and validate with EDD/ADD if available.

Medical Information

1. Medical conditions/recent illnesses: WIC staff will give you a list of medical conditions to review.

2. Does your child take any medicines?
☐ Yes ☐ No
If yes, what kind?  ____________________________
Any side effects?
☐ Yes ☐ No
If yes, what?  ____________________________

3. Was this a:  ☐ Single birth  ☐ Triplet birth  
☐ Twin birth  ☐ More than 3

4. Mother's Height: [_____ feet  _____ inches]
5. Mother's Weight: [_____ pounds]

   This should be answered by the biological mother only. What is your current height and weight? (OR if you are pregnant now or had a baby in the past 6 months, what was your weight before that pregnancy?)

6. Father's Height: [_____ feet  _____ inches]
7. Father's Weight: [_____ pounds]

   (This should be answered by the biological father only)

8. Does anyone living in your household smoke inside the home?  (CDC)
☐ Yes  ☐ No  ☐ Unknown

9. About how many hours did your child sit and watch television or videos yesterday?  (CDC)
☐ > 0 and < 1 hour  ☐ 4 hours  
☐ 1 hour  ☐ 5 or more hours  
☐ 2 hours  ☐ None  
☐ 3 hours  ☐ Unknown

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**BF Statistics Tab (CDC)**

Was this child ever breastfed or fed breast milk?
- Yes
- No
- Unknown

Is this child currently breastfed?
- Yes
- No
- On Demand
- Scheduled

How old was this child when he/she was **first fed** something other than breast milk?
- Exclusively Breastfed (Check here if child has never had anything except breast milk)
  - Age: ______ Month ______ Weeks ______ Days
- Unknown

**Type of Food:**
- Cereal
- Cow's Milk
- Formula
- Fruit Juice
- Vegetable
- Water
- No Information Provided

(Answer the next question if your child is no longer getting breast milk)

How old was this child when he/she completely stopped breastfeeding or being fed by breast milk?
- Age: ______ Month ______ Weeks ______ Days
- Unknown

**Reason Breastfeeding Ended:**
- Baby Distracted
- Breast/Nipple Pain
- Doctor Recommended
- Infant/Child Illness/Condition
- Lack of Support
- Latch Issues/Refused Breast
- Low Milk Supply
- Maternal Illness/Surgery
- Medication
- Mother’s Preference
- Return to School
- Return to Work
- Teething
- Other
- No Information Provided

**Nutrition History**

1. If breastfed, how old was this child when he/she was **routinely** fed something other than breast milk?
   - Age: ______ Month ______ Weeks ______ Days
   - Unknown

   **Type of Food Choices:**
   - Cereal
   - Cow's Milk
   - Formula
   - Meat
   - Fruit
   - Juice
   - Vegetable
   - Water

2. Has your baby’s health care provider/doctor said that your baby has or had:
   - Jaundice
   - A weak suck
   - Poor weight gain
   - Good weight gain
   - Inadequate bowel movements for age
   - None apply

3. If breastfeeding, who ends the nursing session?
   - Mom  Child

4. Does your infant sometimes take expressed breast milk from a bottle, cup or other?
   - Yes
   - No
5. Are you using expressed breast milk?  
   □ Yes  □ No  
   If you have questions about breast milk storage, please comment:

6. Is your infant drinking formula NOW?  
   □ Yes  □ No  
   If yes, Formula Name: ____________________________

7. If feeding formula, how much does your baby usually drink at a feeding?  
   _______ Ounces

8. If feeding formula, is it stored:  
   At room temperature more than 1 hour?  □ Yes  □ No  
   In refrigerator more than 48 hours?  (24 hours if powder)  □ Yes  □ No

9. Do you have access to:  
   Safe water to prepare formula?  □ Yes  □ No  
   A refrigerator to store formula or breast milk?  □ Yes  □ No

10. Which appliances do you use to prepare formula?  
    □ Stove/range  
    □ Hot plate  
    □ Microwave  
    □ Other ____________________________

11. Has your baby been given a bottle of formula or expressed breast milk left over from a previous feeding?  
    □ Yes  □ No

12. Does your infant?  (Check all that apply):  
    □ Take a bottle to bed, nap or while lying down  
    □ Drink from a bottle propped up when feeding  
    □ Eat from a spoon  
    □ Get cereal or infant food in a bottle/infant feeder  
    □ Receive sugar water  
    □ Receive juice in a bottle  
    □ Receive soda/pop in a bottle  
    □ Use a bottle throughout the day as a pacifier  
    □ Sip from a training cup throughout the day  
    □ Eat finger foods  
    □ Take a vitamin or mineral supplement or Vitamin D supplement daily  
    □ Use herbal supplement remedies or tea  
    □ Have any oral/dental problems  
    □ Consume a vegetarian diet  
    □ Follow a special diet  
    □ Take fluoride supplement  
    □ None apply

13. Does your baby eat or drink anything besides breast milk, formula and water?  □ Yes  □ No  
    If yes, check what baby eats or drinks:  
    □ Whole/low fat milk  
    □ Yogurt  
    □ Imitation milk  
    □ Goat/sheep milk  
    □ Vegetables  
    □ Meats  
    □ Fruit  
    □ Cereal  
    □ Teething biscuits  
    □ Table food  
    □ Mixed dinners  
    □ Hot dogs  
    □ Coffee/Tea  
    □ Candy/cookies  
    □ Ice cream  
    □ Chips/donuts  
    □ French fries  
    □ Other ____________________________

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14. Does your infant have any food allergies?
   - Yes  - No

   If yes, what?  

15. Do you use sugar, honey or syrup on a pacifier?
   - Yes  - No

16. Does your infant eat or drink any of the following? (Check all that apply):
   - Raw (unpasteurized) juice or milk
   - Soft cheese (feta, Camembert, Brie, queso blanco, queso fresco, Panela)
   - Honey
   - Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot
   - Raw or undercooked (rare) meat, fish, poultry or egg
   - Raw sprouts
   - Raw or undercooked tofu
   - None apply

17. Did the mother of this infant use alcohol or drugs during pregnancy?
   - Yes  - No

18. Is the mother of this infant mentally impaired?
   - Yes  - No

19. Has your infant been in foster care in the past 6 months?
   - Yes  - No

20. Does a family member have a disability that would make it difficult to plan or prepare food for your baby?
   - Yes  - No

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Staff Notes

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CPA Signature  

Date

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