Infant - Mid-Certification Health and Diet Questions

Today's date: _____/_____/_____ Your baby's name _____

Medical Information Screen

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

2. Does your child take any **medicines:** (Check if yes) ☐ If yes, what kind? _____

   Any side effects? ☐ Yes If yes, what? _____ ☐ No

3. Was this a: ☐ single birth ☐ triplet birth
   ☐ twin birth ☐ more than 3

4. Mother's Height: ☐ ft ☐ in 5. Mother's Weight: ☐ lb

   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: ☐ ft ☐ in 7. Father's Weight: ☐ lb

   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 ☐ 1 hour ☐ 2 hours
   ☐ 3 hours ☐ 4 hours ☐ 5 or more hours
   ☐ None ☐ Unknown

BF Statistics Tab (CDC)

Was this child ever breastfed or fed breast milk?

○ Yes ○ No ○ Unknown

Is this child currently breastfed?

○ Yes ○ No

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)**

Months Weeks Days

Age: ☐ ☐ ☐ ☐ Unknown

Type of Food (Circle One)

Cereal
Cow's Milk
Formula
Fruit Juice
No Information Provided
Vegetable
Water

(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 breast milk?

Months Weeks Days

Age: ☐ ☐ ☐ ☐ Unknown

Reason Breastfeeding Ended (Circle One)

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
No Information Provided
Other
Return to School
Return to Work
Teething

Nutrition History Screen

1. If breastfed, how old was this child when he/she was **routinely** fed something other than breast milk?

   ☐ Months ☐ Weeks ☐ Days

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

   ☐ Has 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?
   (Check if yes): ☐

5. If expressing breast milk, do you feed breast milk that has been refrigerated for longer than 72 hours?
   ☐ Yes ☐ No

6. Is your infant drinking formula NOW? (Check if yes): ☐

   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 less than 48 hours? (24 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 of 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
- ☐ None apply
- ☐ Sip from a training cup throughout the day
- ☐ Eat Finger foods
- ☐ Take a vitamin or mineral supplement daily
  What kind ☐
- ☐ Take a vitamin D supplement daily
- ☐ Use herbal supplement remedies or teas
  What kind ☐
- ☐ Have any dental problems
- ☐ Consume a vegetarian diet
- ☐ Follow a special diet
  If yes, what type? ☐
- ☐ Take fluoride supplement

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's/sheep's milk
- ☐ Vegetables
- ☐ Meats
- ☐ Fruit
- ☐ Cereal
- ☐ Table Food
- ☐ Mixed Dinners
- ☐ Hot dogs
- ☐ Coffee/tea
- ☐ Candy/cookies
- ☐ Ice cream
- ☐ Chips/donuts
- ☐ French Fries
- ☐ Teething Biscuits
- ☐ Other _____

14. Does your infant have any food allergies? (Check if yes) ☐ If yes, to 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
- ☐ None apply
- ☐ Raw or undercooked (rare) meat, fish, poultry or egg
- ☐ Raw sprouts or raw or undercooked tofu
- ☐ Raw or undercooked tofu
- ☐ Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot

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 this 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

Staff Notes

CPA Signature _____ **Date** _____