



# 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

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: [program.intake@usda.gov](mailto:program.intake@usda.gov). This institution is an equal opportunity provider.

**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  Sip from a training cup throughout the day

Drink from a bottle propped up when feeding  Eat Finger foods

Eat from a spoon  Take a vitamin or mineral supplement daily  
What kind

Get cereal or infant food in a bottle/  
infant feeder  Take a vitamin D supplement daily

Receive sugar water  Use herbal supplement remedies or teas  
What kind

Receive juice in a bottle  Have any dental problems

Receive soda/pop in a bottle  Consume a vegetarian diet

Use a bottle throughout the day as a pacifier  Follow a special diet  
If yes, what type?

None apply  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:

- |   |  |
|---|--|
| <input type="checkbox"/> Whole/low fat milk         | <input type="checkbox"/> Table Food    |
| <input type="checkbox"/> Yogurt                     | <input type="checkbox"/> Mixed Dinners |
| <input type="checkbox"/> Imitation milk             | <input type="checkbox"/> Hot dogs      |
| <input type="checkbox"/> Goat's/sheep's milk        | <input type="checkbox"/> Coffee/tea    |
| <input type="checkbox"/> Vegetables                 | <input type="checkbox"/> Candy/cookies |
| <input type="checkbox"/> Meats                      | <input type="checkbox"/> Ice cream     |
| <input type="checkbox"/> Fruit                      | <input type="checkbox"/> Chips/donuts  |
| <input type="checkbox"/> Cereal                     | <input type="checkbox"/> French Fries  |
| <input type="checkbox"/> Teething Biscuits          |  |
| <input type="checkbox"/> Other <input type="text"/> |  |

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):

- |  |  |
|--|--|
| <input type="checkbox"/> Raw (unpasteurized) juice or milk                                       | <input type="checkbox"/> Raw or undercooked (rare) meat, fish, poultry or egg                    |
| <input type="checkbox"/> Soft cheese (feta, camembert, brie, queso blanco, queso fresco, panela) | <input type="checkbox"/> Raw sprouts or raw or undercooked tofu                                  |
| <input type="checkbox"/> Honey   | <input type="checkbox"/> Raw or undercooked tofu   |
| <input type="checkbox"/> None apply  | <input type="checkbox"/> 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** \_\_\_\_\_