



**Medical Information Screen**



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

2. Check here if your child takes any **medicines**:  If yes, what kind?

Any side effects?  Yes  No

3. Does your child have any **dental problems** that make it difficult to eat?  Yes  No

If yes, what kind?

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**)

Age:      Months      Weeks      Days  
           

- 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?

Age:      Months      Weeks      Days  
           

- 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. Number of **Meals** your child usually eats in a day:  
 0     1     2     3     4     5 or more

3. Number of **Snacks** your child usually eats in a day:  
 0     1     2     3     4     5 or more

4. How many ounces of **milk** does your child drink most days?

5. How many ounces of **juice** does your child drink most days?

6. Is your child's **appetite** usually:     Good     Fair     Poor

7. Check here if your child is on a **special diet**:     If yes, what kind?

8. How many times a week does your child eat **Fast Food**?  
 0     1     2     3     4     5 or more

9. Does your child have any **food allergies**? If yes, to what?

10. Does your child eat or drink any of the following every day or most days? (Check all that apply):

- Skim, ½%, 1% or 2%
- Pop, Koolaid, Sports drinks, flavored water, sweet tea, Jell-O water
- Milk substitutes (rice milk, soy milk, non-dairy creamer, sweetened condensed milk or homemade milks)
- Baby food or blenderized food only
- None apply

11. Does your child eat or drink any of the following? (Check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Raw (unpasteurized) juice or milk                                       | <input type="checkbox"/> Raw sprouts/tofu   |
| <input type="checkbox"/> Soft cheese (feta, camembert, Brie, queso blanco, queso fresco, Panela) | <input type="checkbox"/> Hot dogs, lunchmeats, and other deli meats <u>not reheated to steaming hot</u> |
| <input type="checkbox"/> Raw or undercooked (rare) meat, fish, poultry or eggs                   | <input type="checkbox"/> Michigan fish  |
| <input type="checkbox"/> None apply  |   |

12. Does your child? (Check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Use a bottle                                      | <input type="checkbox"/> Drink juice in a bottle                              |
| <input type="checkbox"/> Sleep with a bottle                               | <input type="checkbox"/> Sip from a training or sippy cup <u>all day long</u> |
| <input type="checkbox"/> Use a bottle all through the day or as a pacifier | <input type="checkbox"/> Use a pacifier dipped in sugar, honey or syrup       |
| <input type="checkbox"/> Take cereal or other food in a bottle             | <input type="checkbox"/> None apply   |

13. Does your child? (Check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Eat a strict vegetarian diet  | <input type="checkbox"/> Choke on his/her food often  |
| <input type="checkbox"/> Eat a low calorie/weight loss diet  | <input type="checkbox"/> Take a fluoride supplement daily   |
| <input type="checkbox"/> Regularly eat non-food items (ashes, carpet fibers, cigarettes or cigarette butts, clay, dust foam rubber, paint chips, soil, laundry or corn starch) | <input type="checkbox"/> Take a vitamin/mineral supplement daily<br>What kind? <input type="text"/> |
| <input type="checkbox"/> Have to eat when he/she doesn't want to   | <input type="checkbox"/> Use herbal supplement remedies or teas<br>What kind? <input type="text"/>  |
| <input type="checkbox"/> Eat only by being spoon-fed (child never feeds self with spoon, fingers, etc.)  | <input type="checkbox"/> None apply   |

14. Has your child been in **foster care** in the past 6 months?  Yes  No

15. Does a family member have a **disability** that would make it difficult to plan or prepare food for your child?  Yes  No

**Staff Notes**

**CPA Signature** \_\_\_\_\_ **Date** \_\_\_\_\_