CHILD HEALTH AND DIET QUESTIONS
(1 THROUGH 4 YEARS OF AGE)

Michigan Department of Health and Human Services

Today's Date		
Your Name	Your baby's birth date	Is your child a ☐ 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 child Hispanic or Latino?	Race: Select one or more	
☐ Yes ☐ No	☐ American Indian or Alaska Native	☐ White
	☐ Asian	☐ European
	☐ Black or African American	☐ North African
	☐ Native Hawaiian or Other Pacific Islander	☐ Middle Eastern

What was your child's birth weight?	What was your due date?
_____ pounds _____ ounces	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:** _____

2. **Medications**?
   ☐ Yes ☐ No
   If yes, what kind? _____
   Any side effects? ☐ Yes ☐ No
   If yes, what kind? _____

3. **Dental problems** affecting eating?
   ☐ Yes ☐ No
   If yes, what kind? _____

4. Mother's Height
   _____ feet _____ inches
   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?)

5. Father's Height
   _____ feet _____ inches
   Father's Weight
   _____ pounds

This should be answered by the **biological father** only.

6. Does anyone living in your **household smoke** inside the home?
   ☐ Yes ☐ No ☐ Unknown

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

Breastfeeding Information

1. Was this child ever breastfed or fed breast milk, even for a short period of time?
☐ Yes ☐ No ☐ Unknown

2. Is this child currently breastfed or fed breast milk? ☐ Yes ☐ No

3. Was this child given any formula in the hospital?
☐ Yes ☐ No ☐ Unknown

3a. Is this child being fed anything other than break milk? ☐ Yes ☐ No

4. How old was this child when he/she was **first fed** something other than breast milk?
Age _____ Month _____ Weeks _____ Days _____ ☐ Unknown

5. 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:

☐ My baby had difficulty latching or nursing
☐ Breast milk alone did not satisfy my baby
☐ I thought my baby was not gaining enough weight
☐ My nipples were sore, cracked or bleeding or it was too painful
☐ I thought I was not producing enough milk, or my milk dried up
☐ I had too many other household duties
☐ I felt it was the right time to stop breastfeeding
☐ I got sick or I had to stop for medical reasons
☐ I went back to work
☐ I went back to school
☐ Lack of support
☐ My baby had an illness or medical condition
☐ Doctor recommended I supplement or wean
☐ Other _____

Nutrition History

1. Number of meals per day: _____ Number
2. Number of snacks per day: _____ Number
3. Ounces of **Milk** per day? _____ Ounces
4. Ounces of **Juice** per day: _____ Ounces
5. **Appetite**:
☐ Good ☐ Fair ☐ Poor
6. **Special diet**:
_____
7. **Fast Food/week:**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
8. **Food allergies** if any:
☐ Yes ☐ No
If yes, what kind? _____

10. Consumes every day or most days (Check all that apply)

☐ Skim, 1/2%, 1%
☐ Inadequately fortified milk substitutes (rice/ soy, etc.)
☐ Pop, Kool-Aid, Sports drinks, etc.
☐ Baby Food **only**
☐ None apply

11. Check all that apply

- ☐ Raw unpasteurized juice/milk
- ☐ Soft cheese
- ☐ Raw/undercooked meat/fish/poultry/eggs
- ☐ Michigan fish
- ☐ Raw sprouts
- ☐ Hot dogs, lunchmeats **not steaming**
- ☐ None apply

12. Check all that apply

- ☐ Use a bottle
- ☐ Sleep with a bottle
- ☐ Bottle all day
- ☐ Cereal/food in bottle
- ☐ Juice in a bottle
- ☐ Training cup **all day**
- ☐ Pacifier with honey, etc.
- ☐ None apply

13. Check all that apply

- ☐ Vegetarian diet
- ☐ Low calorie/weight loss diet
- ☐ PICA
- ☐ Have to eat food doesn't want
- ☐ Only spoon-fed
- ☐ Chokes often
- ☐ Fluoride
- ☐ Vitamin/mineral/Vitamin D
  What kind? _____
- ☐ Have history of bariatric surgery
- ☐ Herbal remedies/teas
  What kind? _____
- ☐ None apply

14. **Foster care** (in the past 6 months)? ☐ Yes ☐ No

15. Does the caregiver have any of the following? (check all that apply)

- ☐ Substance use disorder
- ☐ A mental health condition
- ☐ An intellectual disability
- ☐ A physical disability
- ☐ 17 years of age or younger
- ☐ None apply

16. Did you provide MIHP Service for this client during this visit? ☐ Yes ☐ No

Staff Notes

CPA Signature	Date

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Authority: Act 368 PA 1978

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