

**MATERNAL INFANT HEALTH PROGRAM (MIHP)
SUPPLEMENTAL NUTRITION ASSESSMENT**

Name of Parent(s): _____ Date: _____

Name of Infant: _____

Physician order in place for Registered Dietitian YES NO Date: _____

INFANT'S NUTRITION

1. Are you currently breastfeeding this baby? YES NO
2. If no, has this infant ever breastfed or fed breastmilk? YES NO
3. How old was this baby when (s)he was first fed something other than breastmilk? _____
4. How old was this baby when (s)he completely stopped breastfeeding? _____
5. If currently breastfeeding please check all that are true:
 - a. My infant's breastfeeding experience is : Wonderful Good OK Difficult
 - b. My infant has trouble latching onto the breast: YES NO
6. In 24 hours, how many wet diapers? _____ How many messy (BM) diapers? _____
7. Is your infant drinking formula now? YES NO
8. If yes, formula name: _____
9. If yes, how many formula feedings in 24 hours? _____
10. Is the formula: Powdered Liquid concentrate Ready to use
11. If you mix formula with water, how much water do you add? _____
12. How much formula does your infant usually drink at a feeding? _____
13. Has your infant been given a bottle of formula or expressed breast milk left over from a previous feeding?
 YES NO
14. How much water does your infant usually drink in 24 hours? _____
15. How many times in 24 hours does you infant get fed? _____
16. Do you have access to safe water to prepare the formula? YES NO
17. Do you have a refrigerator to store formula or breastmilk? YES NO
18. Is your infant's formula stored at room temperature longer than 2 hours? YES NO
19. Is you infant's formula store in the refrigerator longer than 48 hours? YES NO
20. Which appliance do you use to prepare formula? Stove/range Hot plate Microwave Other
21. Does your baby eat/drink anything besides breastmilk, formula and water? YES NO

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22. Please check all that the baby eats/drinks:

Whole Milk Low Fat Milk Imitation Milk Goat's Sheep's Milk Vegetables Meats

Fruit Cereal Teething Biscuits Table Food Mixed Dinners Hot Dogs

Other: _____

23. Do you add sugar, honey, or syrup to any drinks or food, or use it on a pacifier? YES NO

PARENT(S)/ CAREGIVER'S NUTRITION

1. What changes, if any, have been made in parent(s) eating habits since the baby was born?

2. Have parent(s) ever had an eating disorder? YES NO

If yes, please describe: _____

3. Do parent(s) have enough food? YES NO

 a. For others in the household? YES NO

 b. Is there a stove? YES NO

4. Currently enrolled in WIC? YES NO

5. Receive food benefits through DHS? YES NO

6. Other resources for food? _____

Comments:

Signature: _____

Date: _____

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