INFANT HEALTH AND DIET QUESTIONS  
(BIRTH THROUGH 1 YEAR OF AGE)  
Michigan Department of Health and Human Services

Today's Date

Your Name  

Your baby's birth date

Is your baby 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 baby Hispanic or Latino?  

☐ Yes  ☐ No

Race: Select one or more  

☐ 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 baby's birth weight?  

_____ pounds  _____ ounces

What was your baby’s birth length?  

_____ inches

What was your due date?  

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: WIC staff will give you a list of medical conditions to review.

2. Does your child take medicines?  

☐ Yes  ☐ No

Any side effects?

If yes, what kind?  

☐ Yes  ☐ No

If yes, what kind?

3. Was this a:  

☐ Single Birth  ☐ Twin Birth  ☐ Triplet Birth  ☐ More than 3

4. Mother’s Height  

_____ feet  _____ inches

5. 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?)

6. Father’s Height  

_____ feet  _____ inches

7. Father’s Weight  

_____ pounds

This should be answered by the biological father only.

8. Does anyone living in your household smoke inside the home?  

☐ Yes  ☐ No  ☐ Unknown

9. About how many hours did your child sit and watch television or videos yesterday?  

☐ > 0 and < 1 hour  ☐ 4 hours

☐ 1 hour  ☐ 5 hours or more hours

☐ 2 hours  ☐ None

☐ 3 hours  ☐ Unknown
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 _____  Month _____  Weeks _____  Days _____  Unknown

Type of Food:
- Cereal
- Cow’s Milk
- Formula
- Fruit
- Vegetable
- Water
- Juice
- No Information Provided

(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 by breast milk?
- Age _____  Month _____  Weeks _____  Days _____  Unknown

Reason Breastfeeding Ended:
- Baby Distracted
- Medication
- Breast/Nipple Pain
- Mother’s Preference
- Doctor Recommended
- Return to School
- Infant/Child Illness/Condition
- Return to Work
- Lack of Support
- Teething
- Latch Issues/Refused Breast
- Other
- Low Milk Supply
- No Information Provided
- Maternal Illness/Surgery

Nutrition History

1. If breastfed, how old was this child when he/she was routinely fed something other than breast milk?
- Age _____  Month _____  Weeks _____  Days _____  Unknown

Type of Food:
- Cereal
- Cow’s Milk
- Formula
- Meat
- Fruit
- Vegetable
- Water
- Juice

2. Has your baby’s health care provider/doctor said that your baby has or had:
   - Jaundice
   - Good weight gain
   - A weak suck
   - Inadequate bowel movements for age
   - Poor weight gain
   - None apply

3. If breastfeeding, who ends the nursing session?
   - Mom
   - Child

4. Does your baby take expressed breast milk?
   - Yes
   - No
   If you have questions about breast milk storage, please comment:

5. Does your baby take formula?
   - Yes
   - No
   If yes, Formula Name ___________________________

6. Do you have access to:
   - Safe water to prepare formula?
     - Yes
     - No
   - A refrigerator to store formula or breast milk?
     - Yes
     - No
7. Which appliances do you use to prepare formula?
   - Stove/range
   - Hot plate
   - Microwave
   - Other __________________________

8. Has your baby been given a bottle of formula or expressed breast milk left over from a previous feeding?
   - Yes
   - No

9. Does your baby? (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 or 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
   - Sip from a training cup throughout the day
   - Eat from a spoon
   - Take a vitamin or mineral supplement or Vitamin D supplement daily
   - Use herbal supplement remedies or tea
   - Have any oral/dental problems
   - Consume a vegetarian diet
   - Follow a special diet
   - Take fluoride supplement
   - None apply

10. Does your baby eat or drink anything besides breast milk, formula and water?
    - Yes
    - No

   If yes, please check what baby eats or drinks:
   - Whole/low fat milk
   - Yogurt
   - Imitation milk
   - Vegetables
   - Meats
   - Fruit
   - Cereal
   - Teething biscuits
   - Table food
   - Mixed dinners
   - Hot dogs
   - Coffee/Tea
   - Candy/cookies
   - Ice cream
   - Chips/donuts
   - French fries
   - Other __________________________
   - None of the above

11. Does your baby have any food allergies?
    - Yes
    - No

    If yes, what type?

12. Do you use sugar, honey or syrup on a pacifier?
    - Yes
    - No

13. Does your baby 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
   - Donor human milk (acquired directly from individuals or the Internet)
   - Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot
   - Raw or undercooked (rare) meat, fish, poultry or egg
   - Raw sprouts
   - None apply

14. Has your baby been in 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 physical disability
   - A mental health condition
   - 17 years of age or younger
   - An intellectual disability
   - None apply

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