INFANT HEALTH AND DIET QUESTIONS

(Birth through 1 year of age)

Michigan Department of Health and Human Services

Today's date

Your baby's name	Your baby's birth date: Month/Day/Year_____	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?	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 baby's birth weight?	What was your baby's birth length?
_____ pounds _____ ounces	_____ inches
When was your baby born? Month/Day/Year_____	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 any **medicines**?
   ☐ Yes ☐ No
   If yes, what kind? _____
   Any side effects?
   ☐ Yes ☐ No
   If yes, what? _____

3. Was this a: ☐ Single birth ☐ Triplet birth ☐ Twin 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? (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
- ☐ On Demand ☐ Scheduled

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 Juice
- ☐ Vegetable
- ☐ Water
- ☐ 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
- ☐ 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
- ☐ Return to School
- ☐ Return to Work
- ☐ Teething
- ☐ Other
- ☐ No Information Provided

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 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
- ☐ 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?

   ☐ Yes ☐ No

5. Are you using expressed breast milk?
☐ Yes ☐ No
If you have questions about breast milk storage, please

6. Is your infant drinking formula NOW?
☐ Yes ☐ No
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 more than 48 hours? (24 hours 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
☐ 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 finger foods
☐ Take a vitamin or mineral supplement or Vitamin D supplement daily
What kind? _____
☐ Use herbal supplement remedies or tea
What kind? _____
☐ Have any oral/dental problems
☐ Consume a vegetarian diet
☐ Follow a special diet
If yes, what type?
☐ Take fluoride supplement
☐ None apply

13. Does your baby eat or drink anything besides breast milk, formula and water? ☐ Yes ☐ No
If yes, check what baby eats or drinks:
☐ Whole/low fat milk
☐ Yogurt
☐ Imitation milk
☐ Goat/sheep milk
☐ Vegetables
☐ Meats
☐ Fruit
☐ Cereal
☐ Teething biscuits
☐ Table food
☐ Mixed dinners
☐ Hot dogs
☐ Coffee/Tea
☐ Candy/cookies
☐ Ice cream
☐ Chips/donuts
☐ French fries
☐ Other _____

14. Does your infant have any food allergies?
☐ Yes ☐ No
If yes, 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):

☐ 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

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 your 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**

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