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
   If yes, what kind? _____
   Any side effects? ☐ 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? (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 hours 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 _____ 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
☐ 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:
☐ 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
☐ 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 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 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, why type? _____
- ☐ 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 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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