**INFANT HEALTH AND DIET QUESTIONS**  
(Birth through 1 year of age)  
Michigan Department of Health and Human Services

Today's date

<table>
<thead>
<tr>
<th>Your baby's name</th>
<th>Your baby's birth date: Month/Day/Year____________</th>
<th>Is your baby a: □ Boy □ Girl</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Is your baby Hispanic or Latino?</th>
<th>Race: Select one or more:</th>
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<tbody>
<tr>
<td>□ Yes □ No</td>
<td>□ American Indian or Alaska Native</td>
</tr>
<tr>
<td></td>
<td>□ Black or African American</td>
</tr>
<tr>
<td></td>
<td>□ Native Hawaiian or Other Pacific Islander</td>
</tr>
<tr>
<td></td>
<td>□ White</td>
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<tr>
<td></td>
<td>□ Asian</td>
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<tr>
<td></td>
<td>□ European</td>
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<tr>
<td></td>
<td>□ North African</td>
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<td></td>
<td>□ Middle Eastern</td>
</tr>
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What was your baby’s birth weight? _____ pounds _____ ounces  
What was your baby’s birth length? _____ 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  
    - [ ] Receive any oral/dental problems  
    - [ ] Consume a vegetarian diet  
    - [ ] Have any oral/dental problems  
    - [ ] Follow a special diet  
    - [ ] 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               |

<table>
<thead>
<tr>
<th>16. Does your infant eat or drink any of the following? (Check all that apply):</th>
</tr>
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<tbody>
<tr>
<td>☐ Raw (unpasteurized) juice or milk</td>
</tr>
<tr>
<td>☐ Soft cheese (feta, Camembert, Brie, queso blanco, queso fresco, Panela)</td>
</tr>
<tr>
<td>☐ Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot</td>
</tr>
<tr>
<td>☐ Raw or undercooked (rare) meat, fish, poultry or egg</td>
</tr>
<tr>
<td>☐ Honey</td>
</tr>
<tr>
<td>☐ Raw sprouts</td>
</tr>
<tr>
<td>☐ Donor human milk (acquired directly from individuals or the Internet)</td>
</tr>
<tr>
<td>☐ None apply</td>
</tr>
</tbody>
</table>

| 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**

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**CPA Signature**

**Date**

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