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 **medications?**
   ☐ 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?
   ☐ Yes ☐ No ☐ Unknown
9. About how many hours did your child sit and **watch television** or videos yesterday?
   ☐ > 0 and < 1 hour
   ☐ 1 hour
   ☐ 2 hours
   ☐ 3 hours
   ☐ 4 hours
   ☐ 5 hours or more hours
   ☐ None
   ☐ Unknown

Breastfeeding Information

1. Was this child ever breastfed or fed breast milk, even for a short period of time?
   ☐ Yes ☐ No ☐ Unknown
2. Is this child currently breastfed or fed breast milk? ☐ Yes ☐ No
3. Was this child given any formula in the hospital?
   ☐ Yes ☐ No ☐ Unknown

3a. Is this child being fed anything other than breast milk? ☐ Yes ☐ No

4. How old was this child when he/she was **first fed** something other than breast milk?
   Age _____ Month _____ Weeks _____ Days _____ ☐ Unknown
5. 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:

- ☐ My baby had difficulty latching or nursing
- ☐ Breast milk alone did not satisfy my baby
- ☐ I thought my baby was not gaining enough weight
- ☐ My nipples were sore, cracked or bleeding or it was too painful
- ☐ I thought I was not producing enough milk, or my milk dried up
- ☐ I had too many other household duties
- ☐ I felt it was the right time to stop breastfeeding
- ☐ I got sick or I had to stop for medical reasons
- ☐ I went back to work
- ☐ I went back to school
- ☐ Lack of support
- ☐ My baby had an illness or medical condition
- ☐ Doctor recommended I supplement or wean
- ☐ Other _____

Breastfeeding Assessment

1. What are some of the things you look for when you are trying to decide if your baby is getting enough to eat?
   - ☐ Not looking for hunger and full cues
   - ☐ < 4 dirty diapers per day (if child is 4 days-2 months)
   - ☐ < 6 wet diapers per day
   - ☐ < 8 feedings per day (if child is less than 2 months old)
   - ☐ If breastfeeding, baby has a weak or ineffective suck.
   - ☐ If breastfeeding, baby has difficulty latching
   - ☐ Baby not satisfied after eating
   - ☐ No concerns

Nutrition History

1. Infant has/had:
   - ☐ Jaundice
   - ☐ A weak suck
   - ☐ Poor weight gain
   - ☐ Good weight gain
   - ☐ Inadequate bowel movements for age
   - ☐ None apply
2. If breastfeeding, who ends the nursing session? ☐ Mom ☐ Child
3. Does your baby take expressed breast milk? ☐ Yes ☐ No

   Tell me how you store breast milk after pumping.

   _____

4. Does your baby take formula?
   ☐ Yes ☐ No
   If yes, Formula Name _____

5. Do you have access to:
   Safe water to prepare formula? ☐ Yes ☐ No
   A refrigerator to store formula or breast milk? ☐ Yes ☐ No

6. Which appliances do you use?
   ☐ Stove/range ☐ Microwave
   ☐ Hot plate ☐ Other _____

7. Fed leftover formula/breast milk? ☐ Yes ☐ No

8. Does your baby? (Check all that apply)
   ☐ Bottle to bed ☐ Vitamin/mineral/Vitamin D supplement
   ☐ Bottle propped What kind? _____
   ☐ Eat from a spoon ☐ Herbal remedies/tea
   ☐ Cereal/food in a bottle What kind? _____
   ☐ Sugar water ☐ Dental problems
   ☐ Juice in a bottle ☐ Vegetarian diet
   ☐ Soda/pop in bottle ☐ Special diet
   ☐ Bottle throughout the day Why type? _____
   ☐ Training cup throughout the day ☐ Fluoride
   ☐ Finger foods ☐ None apply

9. Check what baby eats or drinks:
   ☐ Whole/low fat milk ☐ Mixed dinners
   ☐ Imitation milk ☐ Hot dogs
   ☐ Goat/Sheep's milk ☐ Coffee/Tea
   ☐ Vegetables ☐ Candy/cookies
   ☐ Meats ☐ Ice cream
   ☐ Fruit ☐ Chips/donuts
   ☐ Cereal ☐ French fries
   ☐ Teething biscuits ☐ Other _____
   ☐ Table food

10. Food allergies, if any? ☐ Yes ☐ No

_____

11. Sugar, honey or syrup on a pacifier? ☐ Yes ☐ No

12. Check all that apply:
   ☐ Unpasteurized juice or milk ☐ Hot dogs, lunchmeats not steaming
   ☐ Soft cheeses ☐ Raw/undercooked meat, fish, poultry or eggs
   ☐ Honey ☐ Raw sprouts
   ☐ Donor human milk (acquired directly from individuals or the Internet) ☐ None apply

13. Foster care (in the past 6 months)? ☐ Yes ☐ No

14. 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

15. Did you provide MIHP Service for this client during this visit? ☐ Yes ☐ No

Staff Notes

CPA Signature	Date

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