INFANT – MID-CERTIFICATION HEALTH AND DIET QUESTIONS

Michigan Department of Health and Human Services

Today's Date

Your Baby's Name

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 ☐ 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
☐ 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
- ☐ Baby/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:

   _____

   Safe water to prepare formula? ☐ Yes ☐ No

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 baby food in a bottle/baby 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/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 _____

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

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.
Authority: Act 368 PA 1978
This institution is an equal opportunity provider.