

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 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

4 hours

1 hour

5 or more hours

2 hours

None

3 hours

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:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Cereal | <input type="checkbox"/> Vegetable |
| <input type="checkbox"/> Cow's Milk | <input type="checkbox"/> Water |
| <input type="checkbox"/> Formula | <input type="checkbox"/> No Information Provided |
| <input type="checkbox"/> Fruit Juice | |

(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:

- | | |
|---|--|
| <input type="checkbox"/> Baby Distracted | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Breast/Nipple Pain | <input type="checkbox"/> Mother's Preference |
| <input type="checkbox"/> Doctor Recommended | <input type="checkbox"/> Return to School |
| <input type="checkbox"/> Infant/Child Illness/Condition | <input type="checkbox"/> Return to Work |
| <input type="checkbox"/> Lack of Support | <input type="checkbox"/> Teething |
| <input type="checkbox"/> Latch Issues/Refused Breast | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Low Milk Supply | <input type="checkbox"/> No Information Provided |
| <input type="checkbox"/> Maternal Illness/Surgery | |

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:

- | | |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Cereal | <input type="checkbox"/> Fruit |
| <input type="checkbox"/> Cow's Milk | <input type="checkbox"/> Juice |
| <input type="checkbox"/> Formula | <input type="checkbox"/> Vegetable |
| <input type="checkbox"/> Meat | <input type="checkbox"/> Water |

2. Has your baby's health care provider/doctor said that your baby has or had:

- | | |
|---|---|
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Good weight gain |
| <input type="checkbox"/> A weak suck | <input type="checkbox"/> Inadequate bowel movements for age |
| <input type="checkbox"/> Poor weight gain | <input type="checkbox"/> 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 comment: _____

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):

<input type="checkbox"/> Take a bottle to bed, nap or while lying down	<input type="checkbox"/> Take a vitamin or mineral supplement or Vitamin D supplement daily
<input type="checkbox"/> Drink from a bottle propped up when feeding	What kind? _____
<input type="checkbox"/> Eat from a spoon	<input type="checkbox"/> Use herbal supplement remedies or tea
<input type="checkbox"/> Get cereal or infant food in a bottle/infant feeder	What kind? _____
<input type="checkbox"/> Receive sugar water	<input type="checkbox"/> Have any oral/dental problems
<input type="checkbox"/> Receive juice in a bottle	<input type="checkbox"/> Consume a vegetarian diet
<input type="checkbox"/> Receive soda/pop in a bottle	<input type="checkbox"/> Follow a special diet
<input type="checkbox"/> Use a bottle throughout the day as a pacifier	If yes, what type? _____
<input type="checkbox"/> Sip from a training cup throughout the day	<input type="checkbox"/> Take fluoride supplement
<input type="checkbox"/> Eat finger foods	<input type="checkbox"/> 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:

<input type="checkbox"/> Whole/low fat milk	<input type="checkbox"/> Table food
<input type="checkbox"/> Yogurt	<input type="checkbox"/> Mixed dinners
<input type="checkbox"/> Imitation milk	<input type="checkbox"/> Hot dogs
<input type="checkbox"/> Goat/sheep milk	<input type="checkbox"/> Coffee/Tea
<input type="checkbox"/> Vegetables	<input type="checkbox"/> Candy/cookies
<input type="checkbox"/> Meats	<input type="checkbox"/> Ice cream
<input type="checkbox"/> Fruit	<input type="checkbox"/> Chips/donuts
<input type="checkbox"/> Cereal	<input type="checkbox"/> French fries
<input type="checkbox"/> Teething biscuits	<input type="checkbox"/> 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

<p>16. Does your infant eat or drink any of the following? (Check all that apply):</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding-right: 20px;"> <input type="checkbox"/> Raw (unpasteurized) juice or milk <input type="checkbox"/> Soft cheese (feta, Camembert, Brie, queso blanco, queso fresco, Panela) <input type="checkbox"/> Honey <input type="checkbox"/> Donor human milk (acquired directly from individuals or the Internet) </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot <input type="checkbox"/> Raw or undercooked (rare) meat, fish, poultry or egg <input type="checkbox"/> Raw sprouts <input type="checkbox"/> None apply </td> </tr> </table>	<input type="checkbox"/> Raw (unpasteurized) juice or milk <input type="checkbox"/> Soft cheese (feta, Camembert, Brie, queso blanco, queso fresco, Panela) <input type="checkbox"/> Honey <input type="checkbox"/> Donor human milk (acquired directly from individuals or the Internet)	<input type="checkbox"/> Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot <input type="checkbox"/> Raw or undercooked (rare) meat, fish, poultry or egg <input type="checkbox"/> Raw sprouts <input type="checkbox"/> None apply
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<p>17. Did the mother of this infant use alcohol or drugs during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>18. Is the mother of this infant mentally impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>19. Has your infant been in foster care in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>20. Does a family member have a disability that would make it difficult to plan or prepare food for your baby? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		

Staff Notes

CPA Signature	Date
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