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?
   □ 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
   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?)

5. Mother’s Weight
   _____ pounds

6. Father’s Height
   _____ feet  _____ inches
   This should be answered by the biological father only.

7. Father’s Weight
   _____ pounds

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 hours 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:
   □ 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 □ Microwave
   □ Hot plate □ 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 from a spoon
   - Eat finger foods
   - Take a vitamin or mineral supplement or Vitamin D supplement daily
   - Use herbal supplement remedies or tea
   - Have any oral/dental problems
   - Consume a vegetarian diet
   - Follow a special diet
   - Take fluoride supplement
   - Receive sugar water
   - Have any oral/dental problems
   - Receive juice in a bottle
   - Consume a vegetarian diet
   - Follow a special diet
   - Take fluoride supplement
   - Receive soda/pop in a bottle
   - Consume a vegetarian diet
   - Follow a special diet
   - Take fluoride supplement

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)
    - Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot
    - Raw or undercooked (rare) meat, fish, poultry or egg
    - Honey
    - Raw sprouts
    - Donor human milk (acquired directly from individuals or the Internet)
    - 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 physical disability
    - A mental health condition
    - 17 years of age or younger
    - An intellectual disability
    - None apply

16. Did you provide MIHP Service for this client during this visit?  
    - Yes
    - No
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