CHILD HEALTH AND DIET QUESTIONS  
(1 THROUGH 4 YEARS OF AGE)  
Michigan Department of Health and Human Services

<table>
<thead>
<tr>
<th>Today's Date</th>
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</thead>
<tbody>
<tr>
<td>Your Name</td>
<td>Your baby's birth date</td>
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</tbody>
</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 child Hispanic or Latino?</th>
<th>Race: Select one or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td>□ American Indian or Alaska Native</td>
</tr>
<tr>
<td></td>
<td>□ Asian</td>
</tr>
<tr>
<td></td>
<td>□ Black or African American</td>
</tr>
<tr>
<td></td>
<td>□ Native Hawaiian or Other Pacific Islander</td>
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</table>

What was your child’s birth weight?  
______ pounds  ____ ounces  
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 **medicines**?  
   □ Yes  □ No  
   If yes, what kind?  
   Any side effects?  
   □ Yes  □ No  
   If yes, what kind?  

3. Does your child have any **dental/oral problems** that make it difficult to eat?  
   □ Yes  □ No  
   If yes, what kind?  

4. **Mother’s Height**  
   ______ feet  ______ inches  
   **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?)

5. **Father’s Height**  
   ______ feet  ______ inches  
   **Father’s Weight**  
   ______ pounds  
   This should be answered by the **biological father** only.

7. **Does anyone living in your household smoke** inside the home?  
   □ Yes  □ No  □ Unknown  

8. About how many hours did your child sit and **watch television** or videos yesterday?  
   □ > 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

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)*

<table>
<thead>
<tr>
<th>Age</th>
<th>Month</th>
<th>Weeks</th>
<th>Days</th>
<th>☐ Unknown</th>
</tr>
</thead>
</table>

Type of Food:
☐ Cereal ☐ Vegetable
☐ Cow’s Milk ☐ Water
☐ Formula ☐ Juice
☐ Fruit ☐ 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?

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<tr>
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<th>Days</th>
<th>☐ Unknown</th>
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Reason Breastfeeding Ended:
☐ Baby Distracted ☐ Medication
☐ Breast/Nipple Pain ☐ Mother’s Preference
☐ Doctor Recommended ☐ Return to School
☐ Infant/Child Illness/Condition ☐ Return to Work
☐ Lack of Support ☐ Teething
☐ Latch Issues/Refused Breast ☐ Other _______________________
☐ Low Milk Supply ☐ No Information Provided
☐ Maternal Illness/Surgery

Nutrition History

1. If breastfed, how old was this child when he/she was **routinely** fed something other than breast milk?

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Type of Food Choices
☐ Cereal ☐ Fruit
☐ Cow’s Milk ☐ Juice
☐ Formula ☐ Vegetable
☐ Meat ☐ Water

2. How many **meals** does your child eat most days?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

3. How many **snacks** does your child eat most days?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

4. How many ounces of **milk** does your child drink most days?

<table>
<thead>
<tr>
<th>☐ 0</th>
<th>☐ 1</th>
<th>☐ 2</th>
<th>☐ 3</th>
<th>☐ 4</th>
<th>☐ 5 or more</th>
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Does your child eat yogurt or cheese?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

5. How many ounces of **juice** does your child drink most days?

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<th>☐ 0</th>
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6. Is your **appetite** usually:

☐ Good ☐ Fair ☐ Poor

7. Are you on a **special diet** (prescribe by your doctor)?

☐ Yes ☐ No

If yes, what kind? _______________________

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8. How many times a week do you eat **Fast Food**
- [ ] 0
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5 or more

9. Do you have any **food allergies**?
- [ ] Yes
- [ ] No
  If yes, what kind?

10. Does your child eat or drink any of the following? (Check all that apply)
- [ ] Skim, 1/2%, 1%, or 2%
- [ ] Milk substitutes (rice milk, soy milk, non-dairy creamer, sweetened condensed milk or homemade milks)
- [ ] Pop, Kool-Aid, Sports drinks, flavored water, sweet tea, Jell-O water

11. 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)
- [ ] Raw or undercooked (rare) meat, fish, poultry or egg
- [ ] Michigan fish

12. Does your child? (Check all that apply)
- [ ] Use a bottle
- [ ] Sleep with a bottle
- [ ] Use a bottle all through the day or as a pacifier
- [ ] Take cereal or other food in a bottle
- [ ] Drink juice in a bottle
- [ ] Sip from a training or sippy cup all day long
- [ ] Use a pacifier dipped in sugar, honey or syrup
- [ ] None apply

13. Does your child? (Check all that apply)
- [ ] Eat a strict vegetarian diet
- [ ] Eat a low calorie/weight loss diet
- [ ] Regularly eat non-food items (ashes, carpet fibers, cigarettes or cigarette butts, clay, dust, foam rubber, paint chips, soil, laundry or corn starch)
- [ ] Have to eat when he/she doesn’t want to
- [ ] Eat only by being spoon-fed (child never feeds self with spoon, fingers, etc.)
- [ ] Take a fluoride supplement
- [ ] Take a vitamin or mineral supplement daily
- [ ] Have history of bariatric surgery
- [ ] Use herbal supplement remedies or teas
- [ ] None apply

14. Has your child 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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