

Location of CPA	HT	WT	BMI	HGB	Mom's BMI	Dad's BMI
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Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Infants

Baby's name			Today's date		
Your name			Your relationship to baby (96)		
Birthdate	Date baby was due (50)	Birth weight (51, 59)	Birth length (52)		
Baby's doctor or clinic		Date of last doctor or clinic visit	Were you on WIC during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No (61)		

Please answer the questions below

My baby breastfeeds	
Every _____ hours or _____ times a day and _____ times a night	<input type="checkbox"/> Not breastfed (71, 75)
Check all that apply to your breastfed baby.	
<input type="checkbox"/> Weak suck <input type="checkbox"/> Slow weight gain <input type="checkbox"/> Problems latching on <input type="checkbox"/> My baby has no problems breastfeeding <input type="checkbox"/> Not breastfeeding <input type="checkbox"/> Other _____ (56, 74)	
Did you ever breastfeed your baby? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Still breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Why did you stop? _____ How old was your baby when you stopped? _____	
Was your baby born three or more weeks early? <input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No (50)	
Check any health problems your baby has.	
<input type="checkbox"/> Colic <input type="checkbox"/> Reflux <input type="checkbox"/> Teeth/gums <input type="checkbox"/> Birth defects <input type="checkbox"/> Slow weight gain <input type="checkbox"/> Jaundice (yellow color) <input type="checkbox"/> Other _____ <input type="checkbox"/> None (56, 68, 91, 93, 94)	
List your baby's medicines. <div style="text-align: right;"><input type="checkbox"/> None</div> (93)	
Is your baby up to date on shots? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Has the doctor tested your baby's blood for lead? <input type="checkbox"/> Yes Results _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know (21)	
Do you clean your baby's gums or teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Check all that your baby takes.	
<input type="checkbox"/> Vitamins (vitamin D) <input type="checkbox"/> Iron drops <input type="checkbox"/> Fluoride drops <input type="checkbox"/> Herbs <input type="checkbox"/> Other _____ <input type="checkbox"/> None (30)	
List your baby's food allergies. <div style="text-align: right;"><input type="checkbox"/> None</div> (93)	
How many times a day is your baby's diaper wet or dirty? <div style="text-align: right;">(74)</div>	

If you give your baby bottles, what is in the bottles? <input type="checkbox"/> Breastmilk <input type="checkbox"/> Formula Which formula? _____ <input type="checkbox"/> No bottles used How many ounces a feeding? _____ How often are the feedings? _____ (38)	
If you mix formula, what kind of water do you use? <input type="checkbox"/> Well <input type="checkbox"/> City <input type="checkbox"/> Distilled <input type="checkbox"/> Spring <input type="checkbox"/> Nursery <input type="checkbox"/> I don't mix formula <input type="checkbox"/> Other _____ (38)	
Do you have special instructions for mixing your baby's formula from your doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No (38)	
Do you have any questions about mixing your baby's formula? <input type="checkbox"/> Yes <input type="checkbox"/> No (38)	
If you use bottles for your baby, check all that apply. <input type="checkbox"/> I wash my hands before fixing the bottle. <input type="checkbox"/> I reuse leftover bottles of formula. <input type="checkbox"/> I sterilize the bottles and nipples. <input type="checkbox"/> I wash the bottles with hot, soapy water. <input type="checkbox"/> I use the microwave to warm bottles. <input type="checkbox"/> I do not give bottles. (38)	
Other than breastmilk or formula, what else do you put into the bottle? <input type="checkbox"/> Karo® syrup <input type="checkbox"/> Juice <input type="checkbox"/> Punch <input type="checkbox"/> Cow's milk <input type="checkbox"/> Jell-O® water <input type="checkbox"/> Sugar <input type="checkbox"/> Pop <input type="checkbox"/> Sheep/goat's milk <input type="checkbox"/> Tea/coffee <input type="checkbox"/> Cereal <input type="checkbox"/> Honey <input type="checkbox"/> Water <input type="checkbox"/> Gatorade® <input type="checkbox"/> Kool Aid® <input type="checkbox"/> Baby foods <input type="checkbox"/> Other _____ <input type="checkbox"/> Nothing (36, 38)	
Check all that apply. <input type="checkbox"/> Baby is fed with a spoon <input type="checkbox"/> Baby uses an infant feeder <input type="checkbox"/> Baby drinks from a cup <input type="checkbox"/> Baby's pacifier is dipped in _____ <input type="checkbox"/> Baby feeds self <input type="checkbox"/> Baby goes to bed with a bottle <input type="checkbox"/> Baby's bottle is propped when feeding <input type="checkbox"/> Baby is usually fed away from home (36, 38)	
If your baby has started the following foods, at what age did you start Cereal _____ Vegetables _____ Fruit _____ Juice _____ Meat _____ Dinners _____ Desserts _____ Cow's milk _____ (36, 38)	
Is there a working stove or microwave and refrigerator in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No (38)	
If anyone living in your home smokes, where do they smoke? <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Car <input type="checkbox"/> No one smokes (46)	
During the last six months, has your baby been physically, sexually or verbally abused or neglected? <input type="checkbox"/> Yes <input type="checkbox"/> No (67)	
Do you have any questions or concerns? _____ _____ _____	