# WIC Health History for Children 1–5 Years

<table>
<thead>
<tr>
<th>Child's name</th>
<th>Today's date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your name</td>
<td>Your relationship to child</td>
</tr>
<tr>
<td></td>
<td>(96)</td>
</tr>
<tr>
<td>Child's birth date</td>
<td>Birth weight</td>
</tr>
<tr>
<td></td>
<td>Birth length</td>
</tr>
<tr>
<td>Child's doctor or clinic</td>
<td>Date of last doctor or clinic visit</td>
</tr>
</tbody>
</table>

### Please answer the questions below.

**Did your child ever breastfeed?**
- [ ] Still breastfeeding  [ ] Yes  [ ] No  [ ] Don't know
  - Why did you stop? ____________________________________________ How old was your child when you stopped? _______

**Was your child born three or more weeks early?**
- [ ] Yes  How many weeks? ____________  [ ] No

**Please check all the health problems your child has.**
- [ ] Asthma  [ ] Depression  [ ] Teeth/gums  [ ] Birth defects  [ ] Lactose intolerant  [ ] Other ____________________________  [ ] None

**List your child's medicines.**
- [ ] None

**Is your child up to date on shots?**
- [ ] Yes  [ ] No  [ ] Don't know

**Has the doctor tested your child's blood for lead?**
- [ ] Yes  Results__________________________  [ ] No  [ ] Don't know

**Has your child seen a dentist?**
- [ ] Yes  [ ] No

**Do your child's teeth get brushed?**
- [ ] Yes  [ ] No

**Where do you get your water?**
- [ ] Well  [ ] City  [ ] Store bought  [ ] Other ____________________________

**Check all that your child takes.**
- [ ] Vitamins  [ ] Herbs  [ ] Iron  [ ] Fluoride  [ ] Other ____________________________  [ ] None

**List your child's food allergies.**
- [ ] None

**Is your child on a special diet?**
- [ ] Yes, your choice  [ ] Yes, from your doctor  [ ] No

**Is your child using formula?**
- [ ] Yes  Which formula? ____________________________  [ ] No
Check all that apply to your child.

- Drinks from a cup
- Drinks from a bottle
- Goes to bed with a bottle or sippy cup
- Walks around with a bottle or sippy cup
- Is fed through a feeding tube

What foods does your child refuse to eat?

- None

Please check all the non-food items your child eats.

- Printed paper
- Paint chips
- Dirt
- Clay
- Ice
- Other

Check all that apply.

- Child feeds self
- I run out of money or food stamps to buy food
- Child has eating/chewing/swallowing problems
- I have a working stove or microwave and refrigerator in my home.
- Child usually does not eat at home
- Child lives in a shelter, hotel or temporary place.

What do you think about your child's eating habits?

How many hours per day is your child physically active?

- Less than one hour
- One–two hours
- Three or more hours

If anyone in your home smokes, where do they smoke?

- Inside
- Outside
- Car
- No one smokes

During the last six months, has your child been physically, verbally or sexually abused or neglected?

- Yes
- No

Do you have any questions or concerns?