

Location of CPA	HT	WT	BMI	HGB	Mom's BMI	Dad's BMI
-----------------	----	----	-----	-----	-----------	-----------

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

<p>My baby breastfeeds</p> <p>Every _____ hours or _____ times a day and _____ times a night <input type="checkbox"/> Not breastfed (71, 75)</p>
<p>Check all that apply to your breastfed baby.</p> <p><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)</p>
<p>Did you ever breastfeed your baby? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Still breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Why did you stop? _____ How old was your baby when you stopped? _____</p>
<p>Was your baby born three or more weeks early? <input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No (50)</p>
<p>Check any health problems your baby has.</p> <p><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)</p>
<p>List your baby's medicines.</p> <p style="text-align: right;"><input type="checkbox"/> None (93)</p>
<p>Is your baby up to date on shots? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>
<p>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)</p>
<p>Do you clean your baby's gums or teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Check all that your baby takes.</p> <p><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)</p>
<p>List your baby's food allergies.</p> <p style="text-align: right;"><input type="checkbox"/> None (93)</p>
<p>How many times a day is your baby's diaper wet or dirty? (74)</p>

If you give your baby bottles, what is in the bottles?
 Breastmilk Formula Which formula? _____ 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?
 Well City Distilled Spring Nursery I don't mix formula
 Other _____ (38)

Do you have special instructions for mixing your baby's formula from your doctor?
 Yes No (38)

Do you have any questions about mixing your baby's formula?
 Yes No (38)

If you use bottles for your baby, check all that apply.
 I wash my hands before fixing the bottle. I reuse leftover bottles of formula. I sterilize the bottles and nipples.
 I wash the bottles with hot, soapy water. I use the microwave to warm bottles. I do not give bottles. (38)

Other than breastmilk or formula, what else do you put into the bottle?
 Karo® syrup Juice Punch Cow's milk Jell-O® water
 Sugar Pop Sheep/goat's milk Tea/coffee Cereal
 Honey Water Gatorade® Kool Aid® Baby foods
 Other _____ Nothing (36, 38)

Check all that apply.
 Baby is fed with a spoon Baby uses an infant feeder
 Baby drinks from a cup Baby's pacifier is dipped in _____
 Baby feeds self Baby goes to bed with a bottle
 Baby's bottle is propped when feeding 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?
 Yes No (38)

If anyone living in your home smokes, where do they smoke?
 Inside Outside Car No one smokes (46)

During the last six months, has your baby been physically, sexually or verbally abused or neglected?
 Yes No (67)

Do you have any questions or concerns?

