**Ohio Department of Health • Bureau of Nutrition Services**

**WIC Health History for Infants**

<table>
<thead>
<tr>
<th>Baby's name</th>
<th>Today's date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your name</th>
<th>Your relationship to baby</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birthdate</th>
<th>Date baby was due</th>
<th>Birth weight</th>
<th>Birth length</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(50)</td>
<td>(51, 59)</td>
<td>(52)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Baby's doctor or clinic</th>
<th>Date of last doctor or clinic visit</th>
<th>Were you on WIC during this pregnancy?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Yes  ☐ No</td>
</tr>
</tbody>
</table>

**Please answer the questions below**

**My baby breastfeeds**

Every _______ hours or ________ times a day and _______ times a night ☐ Not breastfed

Check all that apply to your breastfed baby.

☐ Weak suck ☐ Slow weight gain ☐ Problems latching on ☐ My baby has no problems breastfeeding

☐ Not breastfeeding ☐ Other _____________________________________________

Did you ever breastfeed your baby?  ☐ Yes  ☐ No

Still breastfeeding?  ☐ Yes  ☐ No

Why did you stop? ____________________________ How old was your baby when you stopped? ______

Was your baby born three or more weeks early?  ☐ Yes  How many weeks? ____________  ☐ No

Check any health problems your baby has.

☐ Colic ☐ Reflux ☐ Teeth/gums ☐ Birth defects ☐ Slow weight gain ☐ Jaundice (yellow color)

☐ Other _____________________________________________ ☐ None

List your baby's medicines.

☐ None

Is your baby up to date on shots?  ☐ Yes  ☐ No  ☐ Don’t know

Has the doctor tested your baby's blood for lead?  ☐ Yes  Results ____________________________  ☐ No  ☐ Don’t know

Do you clean your baby's gums or teeth?  ☐ Yes  ☐ No

Check all that your baby takes.

☐ Vitamins (vitamin D) ☐ Iron drops ☐ Fluoride drops ☐ Herbs

☐ Other _____________________________________________ ☐ None

List your baby's food allergies.

☐ None

How many times a day is your baby's diaper wet or dirty?  (74)
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? ________________

If you mix formula, what kind of water do you use?
- [ ] Well
- [ ] City
- [ ] Distilled
- [ ] Spring
- [ ] Nursery
- [ ] I don’t mix formula
- [ ] Other ________________________________

Do you have special instructions for mixing your baby’s formula from your doctor?
- [ ] Yes
- [ ] No

Do you have any questions about mixing your baby’s formula?
- [ ] Yes
- [ ] No

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.

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

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

If your baby has started the following foods, at what age did you start
- Cereal _____ Vegetables _____ Fruit _____ Juice _____ Meat _____ Dinners_____ Desserts_____ Cow’s milk _____

Is there a working stove or microwave and refrigerator in your home?
- [ ] Yes
- [ ] No

If anyone living in your home smokes, where do they smoke?
- [ ] Inside
- [ ] Outside
- [ ] Car
- [ ] No one smokes

During the last six months, has your baby been physically, sexually or verbally abused or neglected?
- [ ] Yes
- [ ] No

Do you have any questions or concerns?