

WIC Health History for Infants

Baby's name	Baby's birth date	Birth weight (51, 57, 59)
Your name	Your relationship to baby (96)	Birth length (52)
Baby's doctor or clinic	Last doctor or clinic visit	

Check Yes, No, or Don't Know to answer questions below.	Yes	No	Don't Know	DO NOT WRITE IN THIS PART
Were you on WIC during this pregnancy?				(61) Location of CPA?
Was the baby born early? If yes, how many weeks?				(50)
Is the baby breastfed now?				(71)
Was the baby ever breastfed? If yes, for how long? _____ Reason for weaning				
Does the baby have at least five wet diapers in 24 hours?				(74, 75)
Does the baby have at least two "dirty" diapers in 24 hours?				(74, 75)
Does the baby have: <input type="checkbox"/> weak suck <input type="checkbox"/> slow weight gain <input type="checkbox"/> jaundice <input type="checkbox"/> problems latching on				(56, 74)
Is the baby fed formula? If yes, which one?				Wt. _____ (53)
Is the baby's bottle ever heated in a microwave?				Length _____ (52)
Is the formula made with water from the faucet? If yes, water is from <input type="checkbox"/> well <input type="checkbox"/> city <input type="checkbox"/> other <i>specify</i>				HC _____ (58)
Is there a working refrigerator and stove or microwave in your home?				(38) Hgb/Hct _____ (20)
If you bottle feed your baby, do you: • wash your hands before fixing the bottle?				(38) How is formula
• wash the bottles with hot, soapy water?				(38) mixed? _____ (38)
• reuse leftover bottles of formula?				(38)
Do you prop the baby's bottle? If yes, when?				(36)
Do you put the baby to bed with a bottle?				(36)
Is anything other than breast milk or formula put into the bottle? <i>Check which ones.</i> <input type="checkbox"/> Karo syrup <input type="checkbox"/> juice <input type="checkbox"/> cows milk <input type="checkbox"/> baby foods <input type="checkbox"/> sugar <input type="checkbox"/> punch <input type="checkbox"/> sheeps milk <input type="checkbox"/> tea/coffee <input type="checkbox"/> honey <input type="checkbox"/> pop <input type="checkbox"/> water <input type="checkbox"/> Gatorade <input type="checkbox"/> jello water <input type="checkbox"/> KoolAid <input type="checkbox"/> cereal <input type="checkbox"/> other				(36, 38) Mom BMI _____ (55) Dad BMI _____ (55)
Is the baby fed with a spoon?				(38)
Does the baby drink from a cup?				(36)
Does the baby feed him/herself?				(38)
Is the baby allergic to any foods? Which ones?				(93)
Is the baby on a special diet? <input type="checkbox"/> from your doctor <input type="checkbox"/> your choice				(30, 35, 38, 91)
Does the baby have any health or eating problems? <input type="checkbox"/> birth defects <input type="checkbox"/> reflux <input type="checkbox"/> colic <input type="checkbox"/> teeth/gums <input type="checkbox"/> other <i>specify</i>				(68, 93, 94)
Does the baby take any medicine? <i>Please list</i>				(93)

Check Yes, No, or Don't Know to answer questions below.

Yes No Don't Know Do NOT WRITE IN THIS PART

Does the baby take: Check the ones. <input type="checkbox"/> vitamin <input type="checkbox"/> iron drops <input type="checkbox"/> fluoride drops <input type="checkbox"/> herbs				(30)
Is the baby up-to-date on shots?				(21) If 'NO'. Recommend at 12 months
Has the doctor tested the baby's blood for lead? If yes, results				
Do you clean your baby's gums/teeth?				
Does anyone living in your home smoke? If so where? <input type="checkbox"/> inside <input type="checkbox"/> outside				(67)
During the last six months, has the baby been physically, verbally or sexually abused or neglected?				
Are there specific health or nutrition concerns about your baby you would like to discuss? If so, please list: _____				

What do you feed the baby?

(35, 36, 38, 75)

Breastfeeds every _____ hours **or** _____ times per day and _____ times per night
 Bottle-feeds every _____ hours takes _____ ounces a feeding **or** _____ ounces every 24 hours

At what age (in months or weeks) did you begin feeding your baby:
 Formula _____ Cereal _____ Vegetables _____ Juice _____ Fruit _____ Meat _____

Baby or Pureed Food	How much?	How often?	Table Food	How much?	How often?
cereal, box			cereal		
cereal, jar			bread		
juice			100% fruit juice		
vegetable			vegetable		
fruit			fruit		
meat			meat/eggs		
dinners			potatoes		
desserts			noodles, rice		
teething food			snack foods		

STOP HERE

A (63, 65, 66)

Previous objective met? yes no

Mom's code

P HR

Pkg Sgn Date Referral

Notes
