### 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>
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<tbody>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Your name</th>
<th>Your relationship to baby</th>
</tr>
</thead>
<tbody>
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<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>
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<tbody>
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<td></td>
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<td>Yes  No</td>
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### Please answer the questions below

**My baby breastfeeds**

- Every ________ hours or ________ times a day and ________ times a night  
  □ Not breastfed (71, 75)

**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 ____________________________ (56, 74)

**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 (50)

**Check any health problems your baby has.**

- □ Colic
- □ Reflux
- □ Teeth/gums
- □ Birth defects
- □ Slow weight gain
- □ Jaundice (yellow color)
- □ Other ____________________________  □ None (56, 68, 91, 93, 94)

**List your baby's medicines.**

- □ None (93)

**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 (21)

**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 (30)

**List your baby's food allergies.**

- □ None (33)

**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?

______________________________