



Infant - Mid-Certification Health and Diet Questions

Today's date: ____/____/____ Your baby's name _____

Medical Information Screen



1. **Medical conditions**/recent illnesses: WIC Staff will give you a list of medical conditions to review.

2. Does your child take any **medicines**: (Check if yes) If yes, what kind?

Any side effects? Yes If yes, what? No

3. Was this a: single birth triplet birth
 twin birth more than 3

4. Mother's Height: ft in 5. Mother's Weight: lb

This should be answered by the **biological mother** only. What is your current height and weight? (OR if you are pregnant now or had a baby in the past 6 months, what was your weight before that pregnancy?)

6. Father's Height: ft in 7. Father's Weight: lb

This should be answered by the **biological father** only.

8. Does anyone living in your **household smoke** inside the home? (CDC)

Yes No Unknown

9. About how many hours did your child sit and **watch television** or videos yesterday? (CDC)

> 0 and < 1 hour 1 hour 2 hours
 3 hours 4 hours 5 or more hours
 None Unknown

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BF Statistics Tab

(CDC)

Was this child ever breastfed or fed breast milk?

- Yes No Unknown

Is this child currently breastfed?

- Yes No

How old was this child when he/she was **first fed** something other than breast milk?

- Exclusively Breastfed (**Check here if child has never had anything except breast milk**)

Age: Months Weeks Days

 Unknown

Type of Food (Circle One)

Cereal
Cow's Milk
Formula
Fruit Juice
No Information Provided
Vegetable
Water

(Answer the next question if your child is no longer getting breast milk)

How old was this child when he/she completely stopped breastfeeding or being fed breast milk?

Age: Months Weeks Days

 Unknown

Reason Breastfeeding Ended (Circle One)

Baby distracted
Breast/Nipple Pain
Doctor recommended
Infant/Child Illness/Condition
Lack of Support
Latch Issues/Refused Breast
Low Milk Supply
Maternal Illness/Surgery
Medication
Mother's Preference
No Information Provided
Other
Return to School
Return to Work
Teething

Nutrition History Screen



1. If breastfed, how old was this child when he/she was **routinely** fed something other than breast milk?

Months

Weeks

Days

Type of Food Choices: Cereal Cow's Milk Formula Meat
 Fruit Juice Vegetable Water

2. Has your baby's health care provider/doctor said that your baby has or had:

- Jaundice
- A weak suck
- Poor weight gain
- Good weight gain
- Has inadequate bowel movements for age
- None apply

3. If breastfeeding who ends the nursing session? Mom Child

4. Does your infant sometimes take expressed breast milk from a bottle, cup or other?
(Check if yes):

5. If expressing breast milk, do you feed fresh breast milk stored in the refrigerator for longer than 72 hours?
 Yes No

6. Is your infant drinking formula NOW? (Check if yes):

If yes, Formula Name:

7. If feeding formula, how much does your baby usually drink at a feeding? Ounces

8. If feeding formula, is it stored:

At room temperature more than 2 hours? Yes No

In refrigerator more than 48 hours? Yes No

9. Do you have access to:

Safe water to prepare formula? Yes No

A refrigerator to store formula or breast milk ? Yes No

10. Which appliances do you use to prepare formula? Stove/range Hot plate Microwave Other

11. Has your baby been given a bottle of formula or expressed breast milk left over from a previous feeding?

Yes No

12. Does your infant? (Check all that apply):

Take a bottle to bed, nap or while lying down Sip from a training cup throughout the day

Drink from a bottle propped up when feeding Eat Finger foods

Eat from a spoon Take a vitamin or mineral supplement daily
What kind

Get cereal or infant food in a bottle/infant feeder Use herbal supplement remedies or teas
What kind

Receive sugar water Have any dental problems

Receive juice in a bottle Consume a vegetarian diet

Receive soda/pop in a bottle Follow a special diet
If yes, what type?

Use a bottle throughout the day as a pacifier Take fluoride supplement

None apply

13. Does your baby eat or drink anything besides breast milk, formula and water? Yes No
If yes, check what baby eats or drinks:

- | | |
|---|--|
| <input type="checkbox"/> Whole/low fat milk | <input type="checkbox"/> Table Food |
| <input type="checkbox"/> Imitation milk | <input type="checkbox"/> Mixed Dinners |
| <input type="checkbox"/> Goat's/sheep's milk | <input type="checkbox"/> Hot dogs |
| <input type="checkbox"/> Vegetables | <input type="checkbox"/> Coffee/tea |
| <input type="checkbox"/> Meats | <input type="checkbox"/> Candy/cookies |
| <input type="checkbox"/> Fruit | <input type="checkbox"/> Ice cream |
| <input type="checkbox"/> Cereal | <input type="checkbox"/> Chips/donuts |
| <input type="checkbox"/> Teething Biscuits | <input type="checkbox"/> French Fries |
| <input type="checkbox"/> Other <input type="text"/> | |

14. Does your infant have any food allergies? (Check if yes) If yes, to what?

15. Do you use sugar, honey or syrup on a pacifier? Yes No

16. Does your infant eat or drink any of the following? (Check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Raw (unpasteurized) juice or milk | <input type="checkbox"/> Raw or undercooked (rare) meat, fish, poultry or egg |
| <input type="checkbox"/> Soft cheese (feta, camembert, brie, queso blanco, queso fresco, panela) | <input type="checkbox"/> Raw sprouts or raw or undercooked tofu |
| <input type="checkbox"/> Honey | <input type="checkbox"/> Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot |
| <input type="checkbox"/> None apply | |

17. Did the mother or this infant use alcohol or drugs during pregnancy? Yes No
18. Is the mother of this infant mentally impaired? Yes No
19. Has your infant been in foster care in the past 6 months? Yes No
20. Does a family member have a disability that would make it difficult to plan or prepare food for your baby? Yes No

Staff Notes

CPA Signature _____ **Date** _____