Ohio Department of Health • Bureau of Nutrition Services  
WIC Health History for Children 1–5 Years

<table>
<thead>
<tr>
<th>Child's name</th>
<th>Today's date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your name</td>
<td>Your relationship to child (96)</td>
</tr>
<tr>
<td>Child's birth date</td>
<td>Birth weight (51, 59)</td>
</tr>
<tr>
<td>Child's doctor or clinic</td>
<td>Birth length</td>
</tr>
<tr>
<td></td>
<td>Date of last doctor or clinic visit</td>
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</tbody>
</table>

Please answer the questions below.

Did your child ever breastfeed?  
☐ Still breastfeeding  ☐ Yes  ☐ No  ☐ Don't know  
Why did you stop? ___________________________  
How old was your child when you stopped? ___________________________

Was your child born three or more weeks early?  
☐ Yes  ☐ No  
How many weeks? ___________________________ (50)

Please check all the health problems your child has.  
☐ Asthma  ☐ Depression  ☐ Teeth/gums  ☐ Birth defects  ☐ Lactose intolerant  
☐ Other ___________________________ ☐ None (68, 61, 94)

List your child's medicines.  
☐ None (93)

Is your child up to date on shots?  
☐ Yes  ☐ No  ☐ Don't know

Has the doctor tested your child's blood for lead?  
☐ Yes  ☐ Results  ☐ No  ☐ Don't know (21)

Has your child seen a dentist?  
☐ Yes  ☐ No

Do your child's teeth get brushed?  
☐ Yes  ☐ No

Where do you get your water?  
☐ Well  ☐ City  ☐ Store bought  ☐ Other ___________________________

Check all that your child takes.  
☐ Vitamins  ☐ Herbs  ☐ Iron  ☐ Fluoride  
☐ Other ___________________________ ☐ None (30)

List your child's food allergies.  
☐ None (93)

Is your child on a special diet?  
☐ Yes, your choice  ☐ Yes, from your doctor  ☐ No (38, 35, 91, 97)

Is your child using formula?  
☐ Yes  ☐ Which formula? ___________________________ ☐ No (91, 92)

HEA 4450 208
Check all that apply to your child:

- Drinks from a cup  
- Drinks from a bottle  
- Goes to bed with a bottle or sippy cup  
- Walks around with a bottle or sippy cup  
- Is fed through a feeding tube  

What foods does your child refuse to eat?

- None  

Please check all the non-food items your child eats.

- Printed paper  
- Paint chips  
- Dirt  
- Clay  
- Ice  
- Other  
- None  

Check all that apply.

- Child feeds self  
- Child has eating/chewing/swallowing problems  
- Child usually does not eat at home  
- Child lives in a shelter, hotel or temporary place  
- I run out of money or food stamps to buy food  
- I have a working stove or microwave and refrigerator in my home  

What do you think about your child’s eating habits?

How many hours per day is your child physically active?

- Less than one hour  
- One-two hours  
- Three or more hours  

If anyone in your home smokes, where do they smoke?

- Inside  
- Outside  
- Car  
- No one smokes  

During the last six months, has your child been physically, verbally or sexually abused or neglected?

- Yes  
- No  

Do you have any questions or concerns?

______________________________________________________________________________________________________________________________________________________________________________________________________________________________