**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>
<tr>
<td>Your name</td>
<td>Your relationship to baby</td>
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**Birthdate** | **Date baby was due** | **Birth weight** | **Birth length** |
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<td>(50)</td>
<td>(51, 59)</td>
<td>(52)</td>
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**Baby's doctor or clinic** | **Date of last doctor or clinic visit** | **Were you on WIC during this pregnancy?**
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**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 ________________________________  

□ Yes  □ No  

**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  □ No  

□ How many weeks? ____________________________  

**Check any health problems your baby has.**
- □ Colic  
- □ Reflux  
- □ Teeth/gums  
- □ Birth defects  
- □ Slow weight gain  
- □ Jaundice (yellow color)  
- □ Other ________________________________  

□ None  

(56, 58, 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  

(96)

**List your baby’s food allergies.**

□ None  

(93)

**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?
_________________________________________________________________________