Infant Questionnaire

Baby’s Name ____________________________________  Date _________________________

Name of person completing form ____________________ __ Relationship to baby_____________

Please answer these questions to help with your WIC visit today.

1. Does anyone smoke inside your home?  □ Yes  □ No

2. What does your household use for drinking water?
   □ city/town/county water  □ well water  □ bottled water  □ other

3. Does the refrigerator in your home work?  □ Yes  □ No

4. Does the stove in your home work?  □ Yes  □ No

5. In the past month, have there been days when you did not have enough food or money to buy food?  □ Yes  □ No

6. When was your baby's last visit to the doctor?

7. Was your baby born prematurely (early)?  □ Yes  □ No

8. Has the doctor said your baby has any health problems?
   If “yes”, list problem(s):
   □ Yes  □ No

9. What concerns do you have about your baby's health?

10. Most days, do you wash or brush your baby's gums or teeth?  □ Yes  □ No

11. Which of these are problems for your baby?
   □ sucking or swallowing  □ vomiting or spitting up  □ constipation  □ diarrhea
   □ other ________________________________  □ none

12. Which of these does your baby take?
   □ vitamin D  □ other vitamins  □ fluoride supplement  □ medicine from doctor
   □ over-the-counter medicine  □ herbal supplement
   □ other ________________________________  □ none

13. Are your baby's shots up-to-date?  □ Yes  □ No

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14. How many wet diapers does your baby have in 24 hours?

15. How many stools or dirty diapers does your baby have in 24 hours?

16. Is your baby breastfed? □ Yes □ No
   If "yes" how many times in 24 hours do you breastfeed your baby?

17. Is your baby fed breast milk from a bottle? □ Yes □ No

18. Does your baby drink formula? □ Yes □ No
   - If "yes", what kind of formula?
   - How much formula does your baby take in a 24-hour period?

19. How is the formula prepared?

20. If your baby doesn't finish a bottle, what do you do with the leftover breast milk or formula?

21. If your baby takes a bottle:
   - Is your baby held while being fed? □ Yes □ No
   - Is your baby put to bed with a bottle? □ Yes □ No

22. Is your baby fed anything besides breast milk or formula? □ Yes □ No
   If "yes", what else do you give your baby?

23. If your baby drinks anything besides breast milk or formula, what is used? (Check all that apply.)
   □ bottle □ cup with no lid □ cup with lid and spout (sippy cup) □ other

24. If your baby is fed solid foods, how is food given? (Check all that apply.)
   □ in bottle □ with spoon □ baby feeds self □ other

25. How often is your baby put on the floor for some active play?
   □ most days □ some days □ not very often

26. How often is your baby put in front of the TV?
   □ most days □ some days □ not very often

27. What would you like to talk to the nutritionist about today?

Thank you!