Health and Nutrition Screening Form
Infants 0 - 12 Months

Baby's Name: _____

Date: _____

We want to know about your **wonderful baby!** Please share with us answers to the questions on the next few pages. The answers to these questions will be kept confidential.

Staff use only ▼

Check (√) the answer or fill in the blank:

1. Does your baby take any of the following?

			If **yes**, what kind?	How often?
Vitamins	_____ yes	_____ no	_____	_____
Iron	_____ yes	_____ no	_____	_____
Fluoride	_____yes	_____ no	_____	_____
Medication	_____ yes	_____ no	_____	_____

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2. What is the source of drinking water for your baby?
   _____Artesian well _____Bottled water _____Spring _____City/town

   Is it fluoridated? _____Yes _____No _____Not sure

3. Does anyone else regularly take care of and feed your baby? _____Yes _____No
   Relationship?

4. In what position is your baby put down to sleep? Back_____ Side_____ Tummy_____

5. Is your baby in a home with someone who smokes ? _____Yes _____No
   If **yes**, ☐ 3 days per week or less
   ☐ 4 days per week or more
   ☐ person only smokes outside
   ☐ occasionally

6. Do you wash your baby's teeth or gums? _____Yes _____No

   Do you use anything on your baby's teeth or gums for teething? _____Yes _____No
   If **yes**, what?

7. Does your baby take a bottle to sleep? _____Yes _____No
   If **yes**, what is in the bottle? _____formula _____milk _____water _____other

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8. Were there any days last month when your family didn't have enough food to eat or enough money to buy food? _____ Yes _____ No

9. What questions do you have about feeding your child?

Date assessed:

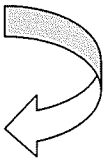
Please answer these questions if you **breastfeed** your baby:

10. How do you feel breastfeeding is going? _____ Good _____Fair _____Poor Do you have any questions or concerns about breastfeeding? _____Yes _____No If yes, please list.	77
11. Over a 24 hour period, how often does your baby breastfeed? _____ How long does baby feed on the first breast? _____ minutes . . . on the second breast? _____minutes	78
12. How many wet diapers does your baby have in 24 hours ?	77
13. How long do you plan to breastfeed? _____12 months or more _____6-12 months _____3-6 months _____6 weeks	
14. Who do you call if you have breastfeeding questions or concerns?	
15. Do you express breastmilk for feedings? _____ Yes _____No What method do you use to express your breastmilk? _____Hand _____Manual Pump _____Electric Pump Where do you store expressed milk? _____ Refrigerator _____Freezer	
16. Will you be returning to work or school? _____Yes _____No	
17. Do you give your baby any other beverages? _____Yes _____No If **yes**, what type?_____ How often? _____ times per day How much? _____ ounces per day	85

Please answer these questions if you **formula feed** your baby:

18. Did you ever breastfeed this baby? ____Yes ____No If **yes**, how long was your baby breastfed? _____ number of weeks At what age was formula started? _____ age in weeks	
19. How do you feel bottle feeding is going? _____Good _____Fair _____Poor Do you have any questions or concerns about bottle feeding? _____Yes _____No If yes, please list.	
20. What kind of formula do you use? _____ (brand name of formula) Type: _____ concentrate _____ powder _____ready to use	85
21. Over a 24 hour period, how much formula does your baby drink? _____ total ounces per day	85
22. Do you give your baby any other beverages? ____Yes ____No If **yes**, what type? _____ How often? _____ times per day How much? _____ ounces per day	85

PLEASE TURN THE PAGE OVER



Solid Food Intake

If you feed your baby solid foods, please complete the table below.
Fill in the types and amounts of foods that your baby is currently eating.

Food	Type	Amount	Times per Day	
Cereal				84
Fruit Juice				85 86
Fruits				86
Vegetables				83
Meat and Meat Substitutes				82
Other Grains, Breads and Cereals				84
Other				85

Thank you for taking the time to complete this form!
Please bring it with you to your WIC appointment.