Infant Health/Nutrition Information

Baby's Name: _____ Birth Date: _____ Age: _____ M / F

1. My baby's **birth weight** was? _____ pounds _____ounces and **length** was: _____ inches.
2. My baby was born **full term** (when due) or **preterm** (early).
3. Were you on the WIC program during your pregnancy? **Yes / No**
4. Does your baby have any medical problems? **Yes / No**
   If **YES**: What problems? _____
5. Does anyone living in your household smoke inside the home? **Yes / No**
6. What month is your baby's next doctor's appointment? _____
7. I give my baby: **Vitamins / Fluoride / Iron Drops / Medicine / None / Other** _____
8. **If you breastfeed your baby:**
   How many times in 24 hours do you breastfeed? _____
   How is breastfeeding going? **(not good) 1……..…..2……..…..3…..……4…..……..5 (great)**
9. **If you feed your baby formula:**
   How often does your baby take a bottle of formula? _____
   How many ounces of formula does your baby drink at a feeding? _____
   What formula are you feeding your baby? _____
   How do you mix the formula? _____ Ounces Water _____ Scoops/Ounces Formula
   How do you clean your baby's bottles? **Wash and dry / Sterilize or boil**
10. My infant uses the following to eat or drink: **Bottle / Cup / Spoon / Fingers / Breast**
11. Where do you give your baby a bottle or cup? **In Bed / Held in someone's arms / Car Seat**
    High Chair / Stroller / Baby holds his/her own bottle / Other _____
12. What does your baby drink from a bottle or cup?

Water / Tea	**Juice / Gatorade**	**Breast Milk / Cereal**	**Soda / Kool-Aid**
Honey / Karo Syrup	**Rice Water**	**Baby Foods**	**Fresh Milk**

13. What do you feed your baby? **Baby Food in Jars / Homemade Baby Food / Table Food / None**
14. Which textures of food do you feed your baby? **Pureed / Chunky/ Chopped/ Soft Pieces/ Other** _____
15. What foods does your baby eat?

Baby Cereal	**Vegetables**	**Fruits**	**Meats / Hot Dogs**
Egg Yolk/Whole Egg	**Chicken / Fish**	**Baby Desserts**	**Peanut Butter**
Bread / Tortillas	**Beans / Cheese**	**Raisins / Cookies**	**Yogurt / Pudding**

16. My baby currently has: **Allergies / Wheezing / Rash / Constipation / Diarrhea / Colic / None**
17. How often do you clean your baby's gums and first teeth? **Never / 1 time a day / 2 or more times a day**
18. What do you think about your baby's size? **Too Little / Too Big / OK**
19. Please circle any problems for which you need help:

Housing	**Access to Food**	**Child Care Services**
Medical Care	**Medical Insurance**	**Dental Services**

20. Are you in a relationship in which you or your baby have been physically hurt or threatened? **Yes / No**
21. What questions do you have about how your baby is eating and growing? _____

For Office Use

PARTICIPANT PRESENT
Y_____
N_____

Foster: Yes

Length: _____

Weight: _____

Hgb: _____

HR Y/N

Interviewer: _____ **Date:** _____

Play With Your Baby --- Learning Begins With Play!

10/2008