

Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Children 1–5 Years

Child's name		Today's date
Your name		Your relationship to child (96)
Child's birth date	Birth weight (51, 59)	Birth length
Child's doctor or clinic		Date of last doctor or clinic visit

Please answer the questions below.

Did your child ever breastfeed? <input type="checkbox"/> Still breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Why did you stop? _____ How old was your child when you stopped? _____
Was your child born three or more weeks early? <input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No (50)
Please check all the health problems your child has. <input type="checkbox"/> Asthma <input type="checkbox"/> Depression <input type="checkbox"/> Teeth/gums <input type="checkbox"/> Birth defects <input type="checkbox"/> Lactose intolerant <input type="checkbox"/> Other _____ <input type="checkbox"/> None (68, 91, 93, 94)
List your child's medicines. <input type="checkbox"/> None (93)
Is your child up to date on shots? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Has the doctor tested your child's blood for lead? <input type="checkbox"/> Yes Results _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know (21)
Has your child seen a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No Do your child's teeth get brushed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Where do you get your water? <input type="checkbox"/> Well <input type="checkbox"/> City <input type="checkbox"/> Store bought <input type="checkbox"/> Other _____
Check all that your child takes. <input type="checkbox"/> Vitamins <input type="checkbox"/> Herbs <input type="checkbox"/> Iron <input type="checkbox"/> Fluoride <input type="checkbox"/> Other _____ <input type="checkbox"/> None (30)
List your child's food allergies. <input type="checkbox"/> None (93)
Is your child on a special diet? <input type="checkbox"/> Yes, your choice <input type="checkbox"/> Yes, from your doctor <input type="checkbox"/> No (30, 35, 91, 93)
Is your child using formula? <input type="checkbox"/> Yes Which formula? _____ <input type="checkbox"/> No (91, 93)

<p>Check all that apply to your child.</p> <p><input type="checkbox"/> Drinks from a cup <input type="checkbox"/> Drinks from a bottle <input type="checkbox"/> Goes to bed with a bottle or sippy cup</p> <p><input type="checkbox"/> Walks around with a bottle or sippy cup <input type="checkbox"/> Is fed through a feeding tube</p> <p style="text-align: right;">(36, 94)</p>
<p>What foods does your child refuse to eat?</p> <p style="text-align: right;"><input type="checkbox"/> None (35)</p>
<p>Please check all the non-food items your child eats.</p> <p><input type="checkbox"/> Printed paper <input type="checkbox"/> Paint chips <input type="checkbox"/> Dirt <input type="checkbox"/> Clay <input type="checkbox"/> Ice</p> <p><input type="checkbox"/> Other _____ <input type="checkbox"/> None (30)</p>
<p>Check all that apply.</p> <p><input type="checkbox"/> Child feeds self <input type="checkbox"/> I run out of money or food stamps to buy food</p> <p><input type="checkbox"/> Child has eating/chewing/swallowing problems <input type="checkbox"/> I have a working stove or microwave and refrigerator in my home.</p> <p><input type="checkbox"/> Child usually does not eat at home</p> <p><input type="checkbox"/> Child lives in a shelter, hotel or temporary place.</p> <p style="text-align: right;">(37, 66, 93, 95)</p>
<p>What do you think about your child's eating habits?</p>
<p>How many hours per day is your child physically active?</p> <p><input type="checkbox"/> Less than one hour <input type="checkbox"/> One–two hours <input type="checkbox"/> Three or more hours</p>
<p>If anyone in your home smokes, where do they smoke?</p> <p><input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Car <input type="checkbox"/> No one smokes</p> <p style="text-align: right;">(46)</p>
<p>During the last six months, has your child been physically, verbally or sexually abused or neglected?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: right;">(67)</p>
<p>Do you have any questions or concerns?</p> <hr/>