

Location of CBS	HT	WT	BMI	HGB	Mom's BMI	Dad's BMI
-----------------	----	----	-----	-----	-----------	-----------

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 <small>(96)</small>
Child's birth date	Birth weight <small>(51, 59)</small>	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 <small>(50)</small>
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 <small>(68, 91, 93, 94)</small>
List your child's medicines. <input type="checkbox"/> None <small>(93)</small>
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 <small>(21)</small>
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 <small>(39)</small>
List your child's food allergies. <input type="checkbox"/> None <small>(93)</small>
Is your child on a special diet? <input type="checkbox"/> Yes, your choice <input type="checkbox"/> Yes, from your doctor <input type="checkbox"/> No <small>(30, 35, 91, 93)</small>
Is your child using formula? <input type="checkbox"/> Yes Which formula? _____ <input type="checkbox"/> No <small>(91, 93)</small>

Check all that apply to your child.

- Drinks from a cup Drinks from a bottle Goes to bed with a bottle or sippy cup
 Walks around with a bottle or sippy cup Is fed through a feeding tube

(36, 94)

What foods does your child refuse to eat?

None

(35)

Please check all the non-food items your child eats.

- Printed paper Paint chips Dirt Clay Ice
 Other _____

None

(30)

Check all that apply.

- Child feeds self I run out of money or food stamps to buy food
 Child has eating/chewing/swallowing problems I have a working stove or microwave and refrigerator in my home.
 Child usually does not eat at home
 Child lives in a shelter, hotel or temporary place.

(37, 66, 93, 95)

What do you think about your child's eating habits?

How many hours per day is your child physically active?

- Less than one hour One-two hours Three or more hours

If anyone in your home smokes, where do they smoke?

- Inside Outside Car No one smokes

(46)

During the last six months, has your child been physically, verbally or sexually abused or neglected?

- Yes No

(67)

Do you have any questions or concerns?
