

## 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 <span style="float: right;">(96)</span>
Child's birth date	Birth weight <span style="float: right;">(51, 59)</span>	Birth length
Child's doctor or clinic		Date of last doctor or clinic visit

**Please answer the questions below.**

<p>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? _____</p>
<p>Was your child born three or more weeks early?  <input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No <span style="float: right;">(50)</span></p>
<p>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 <span style="float: right;">(68, 91, 93, 94)</span></p>
<p>List your child's medicines.  <span style="float: right;"><input type="checkbox"/> None (93)</span></p>
<p>Is your child up to date on shots?  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Don't know</p>
<p>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 <span style="float: right;">(21)</span></p>
<p>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 _____</p>
<p>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 <span style="float: right;">(30)</span></p>
<p>List your child's food allergies.  <span style="float: right;"><input type="checkbox"/> None (93)</span></p>
<p>Is your child on a special diet?  <input type="checkbox"/> Yes, your choice    <input type="checkbox"/> Yes, from your doctor    <input type="checkbox"/> No <span style="float: right;">(30, 35, 91, 93)</span></p>
<p>Is your child using formula?  <input type="checkbox"/> Yes Which formula? _____ <input type="checkbox"/> No <span style="float: right;">(91, 93)</span></p>

<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>	(36, 94)
<p>What foods does your child refuse to eat?</p>	<input type="checkbox"/> None (35)
<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</p>	(30)
<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>	(37, 66, 93, 95)
<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>	(46)
<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>	(67)
<p>Do you have any questions or concerns?</p> <p>_____</p>	