## Ohio Department of Health • Bureau of Nutrition Services

### WIC Health History for Children 1–5 Years

<table>
<thead>
<tr>
<th>Child's name</th>
<th>Today's date</th>
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<tbody>
<tr>
<td>Your name</td>
<td>Your relationship to child</td>
</tr>
<tr>
<td>Child's birth date</td>
<td>Birth weight</td>
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<tr>
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<td>Birth length</td>
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<tr>
<td>Child's doctor or clinic</td>
<td>Date of last doctor or clinic visit</td>
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### Please answer the questions below.

**Did your child ever breastfeed?**
- [ ] Still breastfeeding  
- [ ] Yes  
- [ ] No  
- [ ] Don't know

Why did you stop? ____________________________  How old was your child when you stopped? ________

**Was your child born three or more weeks early?**
- [ ] Yes  
- [ ] How many weeks? _____  
- [ ] No

**Please check all the health problems your child has.**
- [ ] Asthma  
- [ ] Depression  
- [ ] Teeth/gums  
- [ ] Birth defects  
- [ ] Lactose intolerant  
- [ ] Other ____________________________  
- [ ] None (6, 91, 93, 94)

**List your child's medicines.**

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**Is your child up to date on shots?**
- [ ] Yes  
- [ ] No  
- [ ] Don't know

**Has the doctor tested your child's blood for lead?**
- [ ] Yes  
- [ ] Results ____________________________  
- [ ] No  
- [ ] Don't know

**Has your child seen a dentist?**
- [ ] Yes  
- [ ] No

**Do your child's teeth get brushed?**
- [ ] Yes  
- [ ] No

**Where do you get your water?**
- [ ] Well  
- [ ] City  
- [ ] Store bought  
- [ ] Other ____________________________

**Check all that your child takes.**
- [ ] Vitamins  
- [ ] Herbs  
- [ ] Iron  
- [ ] Fluoride  
- [ ] Other ____________________________  
- [ ] None (30)

**List your child's food allergies.**

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**Is your child on a special diet?**
- [ ] Yes, your choice  
- [ ] Yes, from your doctor  
- [ ] No (30, 35, 91, 93)

**Is your child using formula?**
- [ ] Yes  
- [ ] Which formula? ____________________________  
- [ ] No (91, 93)
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

What food does your child refuse to eat?
- None

Please check all the non-food items your child eats.
- Printed paper
- Paint chips
- Dirt
- Clay
- Ice
- Other

Check all that apply.
- Child feeds self
- Child has eating/chewing/swallowing problems
- Child usually does not eat at home
- Child lives in a shelter, hotel or temporary place.

What do you think about your child’s eating habits?
- I run out of money or food stamps to buy food
- I have a working stove or microwave and refrigerator in my home.

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

During the last six months, has your child been physically, verbally or sexually abused or neglected?
- Yes
- No

Do you have any questions or concerns?