Ohio | Department of Health

OHIO WIC
Women, Infants, and Children Program

Ohio Loves Breastfeeding

Complete frontside ONLY

Infant Health Assessment

Date(s): _____ **Infant's Name:** _____

Parent/Guardian Name: _____ **Relationship:** _____

Infant Health History Questions *(please complete all questions on this side – leave the backside blank)*

Were you/baby's mother on WIC during pregnancy? ☐ Yes ☐ No ☐ I don't know

Where does your baby go for healthcare? Doctor/clinic name: _____

Does your baby attend well visits? ☐ Yes ☐ No

Is your baby up to date on shots? ☐ Yes ☐ No ☐ I don't know

Does your baby receive any therapy or other services? ☐ Physical ☐ Occupational ☐ Speech

☐ Home visiting: _____ ☐ Other: _____ ☐ N/A

Does your baby have any medical conditions, or recent surgery, illness, food allergies, or injury? Please describe:

_____

Please list any medication(s) your baby takes: _____ ☐ N/A

Is your baby tube fed? ☐ Yes Please describe: _____ ☐ No

Does your baby have: ☐ Constipation ☐ Diarrhea ☐ Vomiting ☐ Gassiness ☐ N/A

Has anyone in your family been tested for lead? ☐ Yes (levels): _____ ☐ No ☐ I don't know

How do you clean your baby's teeth/gums? _____

Do you live in a temporary place (shelter, hotel, etc.)? ☐ Yes ☐ No

Has your child entered foster care or moved foster care homes, within the past 6 months? ☐ Yes ☐ No

Has your baby been physically, verbally, sexually abused or neglected? ☐ Yes ☐ No

Where does your baby sleep? ☐ Crib ☐ Bassinet ☐ Cribette/Pack n Play ☐ With another person/child ☐ Other

How many wet and dirty diapers does your baby have each day? Wet: _____ Dirty: _____

Do you worry about running out of food? ☐ Yes ☐ No

Do you use local food banks/pantries? ☐ Yes ☐ No

What questions or concerns do you have about your baby's health, eating habits, and breastfeeding? _____

_____

_____