# 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>
</tr>
</thead>
<tbody>
<tr>
<td>Your name</td>
<td>Your relationship to child</td>
</tr>
<tr>
<td>Child's birth date</td>
<td>Birth weight</td>
</tr>
<tr>
<td>Child's doctor or clinic</td>
<td>Date of last doctor or clinic visit</td>
</tr>
</tbody>
</table>

### 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

**List your child's medicines.**
- [ ] None

**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

**List your child's food allergies.**
- [ ] None

**Is your child on a special diet?**
- [ ] Yes, your choice
- [ ] Yes, from your doctor
- [ ] No

**Is your child using formula?**
- [ ] Yes
- [ ] Which formula? ________________________________
- [ ] No
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 foods 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?

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?