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## Ohio Department of Health • Bureau of Nutrition Services WIC Health History for Children 1–5 Years

Child's name				To also de distri	
Cilius Harrie				Today's date	
Your name				Your relationship to child	
					(96)
Child's birth date	Birth weight			Birth length	
			(51, 59)		
Child's doctor or clinic				Date of last doctor or clinic visit	
•					
Please answer the questions below.					
Did your child ever breastfeed?					
_	No □ Don't k	now			
Why did you stop?		Ho	w old wa	as your child when you stopp	oed?
Was your child born three or more weeks early?					
☐ Yes How many weeks?					(50)
Please check all the health problems your child has.				-	
☐ Asthma ☐ Depression ☐	=	☐ Birth defects	LJ La	ctose intolerant 	
Other				None	(68, 91, 93, 94)
List your child's medicines.					
				☐ None	(93)
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 □ Do	n't know	1	(21)
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 bou	ght 🗆 Other_				
Check all that your child takes.					
☐ Vitamins ☐ Herbs ☐ Iron	☐ Fluoride				
☐ Other				None	(30)
List your child's food allergies.					(30)
,				☐ None	(93)
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.					T y'	
☐ Drinks from a cup ☐	Drinks from a bottl	le 🔲 Goes to b	ed with a bottle or sippy cup			
☐ Walks around with a bottle or	sippy cup	$\square$ Is fed thro	ough a feeding tube	(36, 94)		
What foods does your child refuse to eat	<del>!</del> ?		· · · · · · · · · · · · · · · · · · ·	□ None	(35)	
Please check all the non-food items your	child eats.					
☐ Printed paper ☐ Paint cl	hips 🔲 Dirt	☐ Clay	☐ Ice			
☐ Other	<del> </del>			☐ None	(30)	
Check all that apply.						
☐ Child feeds self	y food					
☐ Child has eating/chewing/swal	refrigerator in my hor	me.				
☐ Child usually does not eat at h	iome					
☐ Child lives in a shelter, hotel or	r temporary place.			(	37, 66, 93, 95)	
What do you think about your child's ear	ting habits?	•• .				
How many hours per day is your child ph	nysically active?					
1		☐ Three or more h	oours			
If anyone in your home smokes, where d						
		□ N		•		
☐ Inside ☐ Outside		☐ No one smokes			(46)	
During the last six months, has your child	d been physically, verb	ally or sexually abuse	d or neglected?			
☐ Yes ☐ No					(67)	
Do you have any questions or concerns?						
					<u></u>	
				·		