DIETARY QUESTIONNAIRE FOR INFANTS
Pennsylvania Department of Health -- WIC Program

Infant’s Name: ___________________________ D.O.B.: _________ F.I.D. #: ___________________
Endorser’s Name: _________________________ Date: ______________

1. Was your baby premature? ☐ No ☐ Yes If yes, how many weeks? ____________________________
   Does your baby have any medical problems? ☐ No ☐ Yes Please describe: ____________________________
   Does your baby take any medicine? ☐ No ☐ Yes Please list: ____________________________

2. Describe how your baby is fed: ☐ Breastfed only ☐ Breastfed and formula fed ☐ Formula fed only

3. Breastfeeding mothers please answer these questions (If using formula only, proceed to question #4).

   How many daytime feedings? ______________ Nighttime feedings? ______________
   How long is each feeding? ☐ Less than 5 min. ☐ 5-20 min. ☐ 20-30 min. ☐ More than 30 min.
   Do you have any issues with ☐ Latch ☐ Sore nipples ☐ Milk supply ☐ Fussy baby ☐ Other ☐ No concerns
   Do you plan to return to work? ☐ No ☐ Not sure ☐ Yes Date of return: _________ ☐ Full-time ☐ Part-time

   If you are using a pump, please answer these questions:
   Type of pump? ☐ Hand pump ☐ Single Electric ☐ Double Electric
   What made you decide to pump? ____________________________
   How many times do you pump in 24 hours? ______________ Ounces per session: ______________
   Does pumped milk sit out (not in the refrigerator)? ☐ No ☐ Yes If yes, how long? ______________
   How long is pumped milk stored in the refrigerator? ______________ In the freezer? ______________
   How long do you keep thawed breast milk in the refrigerator? ☐ 1 day ☐ 2 days ☐ 3 days or more
   Do you re-freeze thawed breast milk? ☐ No ☐ Yes
   How are you cleaning your breast pump? ____________________________ How often? ______________

4. If you give your baby any formula, please answer these questions:

   Name of formula (s) ____________________________
   How many daytime feedings? ______________ Nighttime feedings? ______________
   How many ounces per feeding? ______________

   Describe which type of formula you use and how it is prepared:
   Concentrate: ___________ ounces formula with ___________ ounces water
   Powdered: ___________ scoops powder with ___________ ounces water Which is added first? ☐ Water ☐ Powder
   Ready-to-feed: Do you add water? ☐ No ☐ Yes

   What kind of water is used to prepare formula? ☐ Well ☐ Bottled ☐ Nursery ☐ Tap Do you boil the water? ☐ No ☐ Yes
   How long do you keep formula in the refrigerator? ☐ 1 day ☐ 2 days ☐ 3 days or more ☐ Not applicable
   How long does a bottle of formula sit out (not in the refrigerator)? ☐ 1 hour or less ☐ 1 to 2 hours ☐ 2 or more hours ☐ N/A

5. How many bowel movements does your baby have in 24 hours? ______________
   Describe the color: ☐ Yellow/Tan ☐ Green ☐ Brown ☐ Black
   How many wet diapers in 24 hours? ______________ Describe the color: ☐ Light Yellow ☐ Dark Yellow
   Did the doctor say your baby has jaundice? ☐ No ☐ Not sure ☐ Yes

6. Does your baby take any of the following?
   ☐ Multivitamins ☐ Fluoride ☐ Iron ☐ Vitamin D ☐ Herbal teas or supplements
   ☐ Anise Tea ☐ Other ______________ ☐ None of these

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7. Does your baby drink from a bottle? □ No □ Yes
   Where? □ Crib □ Stroller/car seat □ High chair □ Someone holds it □ Baby walks around with it □ Other
   What do you do with breast milk or formula left in the bottle after a feeding? □ Save it for later □ Throw it away □ Other

8. Does your baby use a sippy cup? □ No □ Yes
   When? □ Mealtime □ With snacks □ Walks around with it □ Other
   What goes in the cup? □ Breast milk □ Formula □ 100% juice □ Milk □ Water □ Other ________

9. Check any milk products your baby receives besides breast milk or formula:
   Cow’s milk: □ Whole □ 2% □ 1% □ Skim □ Lactose-free □ Chocolate/Strawberry
   □ Goat’s milk □ Soy milk □ Rice milk □ None of these □ Other ________
   Check any other beverages you give your baby:
   □ Soda □ Kool-Aid □ 100% fruit juice □ Hugs or drinks in pouches, boxes, etc. □ Tea
   □ Juice drinks (Hawaiian punch, Hi-C, Sunny D, etc.) □ Other ________ □ None of these

10. When do you feed your baby? □ When baby is fussy or cries □ On a schedule □ When baby seems hungry
    How do you tell when baby is hungry? ____________________
    How do you tell when baby is full? ______________________

11. Do you offer baby foods? □ No □ Yes □ Which ones? □ Infant Cereal □ Infant fruits or vegetables □ Infant meats □ Other
    Describe the texture: □ Pureed □ With chunks
    How do you feed these foods? □ Bottle □ Spoon □ Infant feeder

   Do you offer table foods? □ No □ Yes
   Describe the texture: □ Pureed □ Mashed □ Finely chopped □ Chunky chopped □ Regular

12. Does your baby receive any of the following foods?
   □ Popcorn/nuts/candy □ Whole grapes □ Hard candy/lollipops □ Seeds/berries/raisins □ Pretzels/chips
   □ Raw vegetables □ Peanut butter □ Gummies/jelly beans □ Hot dogs □ Chunks of meat or cheese

13. Do you add salt, sugar, syrup, or honey to your baby’s foods or drinks? □ No □ Not sure □ Yes

14. Does everyone wash their hands before feeding baby and/or preparing food? □ No □ Not sure □ Yes

15. Do you clean your baby’s gums and teeth? □ No □ Yes

16. Check the items you have at home that work: □ Running water □ Stove □ Refrigerator □ Freezer □ Microwave
    Is there a thermometer in your refrigerator or freezer? □ No □ Yes What is the refrigerator temperature? _____ Freezer? _____

17. Does your baby receive any of the following foods?
   □ Raw or unpasteurized milk □ Honey □ Raw or uncooked eggs, meat, or fish □ Soft cheeses like Feta or Brie
   □ Unpasteurized juice/cider □ Bean sprouts □ Raw cookie dough or cake batter □ Hot dogs, deli or lunch meats

18. Does your baby drink water? □ No □ Yes How many ounces daily? ________________

19. Is your baby allergic to any foods? □ No □ Yes □ Which foods? ______________________

20. Are others in the family allergic to any foods? □ No □ Yes
    Who? □ Parent □ Sister/Brother □ Grandparent □ Other ____________________________
    What foods? □ Soy □ Eggs □ Wheat □ Peanuts/Nuts □ Milk/Milk products □ Other ______________

21. Does anyone smoke in your home? □ No □ Yes

22. Do you ever have to choose between buying food and paying bills? □ Often □ Sometimes □ Rarely □ Never

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