



Diet/Health History for Infants

Today's Date: _____

Infant's Name: _____

DOB: _____ Age: _____

Breastfeeding History for Infants

- Is this infant currently breastfed?
 Yes No
- If no, was this infant *ever* breastfed or fed breastmilk?
 Yes No

Breastfed Infant (Total or Partial)

- How many feedings of breastmilk has this infant had in the past 24 hours? _____
- How long did each feeding last? _____
- Have you had any problems breastfeeding?
 Yes No
If yes, list the problems: _____

- How many wet diapers per day? _____
How many dirty diapers per day? _____

Bottle-Fed Infant (Answer only if bottle-feeding this infant.)

- What type of formula do you use for this infant?
 Powder Concentrated Ready-to-Use
- What is the name of the formula? _____
- How much formula and water are mixed together?

- Do you add anything to the formula besides water?
 Yes No
If yes, what is added? _____
- Is the water boiled before it is mixed with the formula?
 Yes No
- How many bottles do you make at one time? _____
- How much breastmilk or formula do you put in each bottle? _____
- How much breastmilk or formula does this infant drink at each feeding? _____
- How many bottles of breastmilk or formula does this infant drink in 24 hours? _____
- How long does one can of formula last? _____
- What is done with leftover breastmilk or formula in the bottle?

- How are bottles, nipples, etc. cleaned? _____

- How are bottles of breastmilk or prepared formula stored?

All Infants

- Do you always hold this infant during feedings?
 Yes No
- Do you put this infant in bed with a bottle?
 Yes No
- Do you use items (blanket, toy, diaper, etc.) to prop or hold up the bottle?
 Yes No
- Do you let this infant crawl or walk around with the bottle or a cup?
 Yes No
- Do you give this infant the bottle whenever he cries?
 Yes No
- Currently, do you use the bottle to feed liquids other than breastmilk, formula, or water?
 Yes No
If yes, at what age was it first given? _____
What liquid?

a. juice	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. water	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. tea or coffee	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. colas or other sweetened beverages	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. corn syrup, sugar, or salt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. honey	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g. other: _____		
- Have you ever given this infant any **foods** other than breastmilk or formula?
 Yes At what age? _____
 No, skip 27 and 28. Go to 29 on back.
- What foods or beverages, other than breastmilk or formula, have you given this infant in the last 24 hours? (Please list and include amounts.)

- How are solid foods fed to this infant? _____
Does this infant use his or her fingers to eat with?
 Yes No

