Comprehensive Family Nutrition
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Infant Nutrition Questionnaire

1. Please list any current medical problems your child has:_____
   _____
   _____
2. List all past medical problems:_____
   _____
   _____
3. Please list all medications your child is currently taking:_____
   _____
   _____
4. Please list all vitamin/mineral supplements or herbs your child is currently taking:
   _____
   _____
5. Does your child experience problems with constipation or diarrhea? ___yes ___no

Eating Habits:

6. Please tell me about some of your child's eating habits:
   My child gets meals from ___parents ___ daycare ____babysitter ____school ____grandparent other _____.
   My child has a special diet? Yes No
   Type of diet_____
   My child eats: baby foods infant cereal finger foods table foods foods with textures
   How many meals does your child eat a day? _____
   How many snacks does your child eat a day? _____
   What time of day does your child eat snacks? _____
   What kind of snacks does your child like to eat? _____
   Are you breastfeeding/ formula feeding or both? _____
   If you are breastfeeding, how often are you breastfeeding? _____
   How many minutes do you feed on each breast? _____
   Does you child drink milk? If yes what kind _____
   What type of beverages does your child like to drink? _____
   How many cups/day does s/he drink of juice? _____
   What type of water does your child drink? Tap Spring boiled
   My child uses: a bottle cup
7. Please list any question you may have:_____