Infant Nutrition Questionnaire
Birth to 5 Months

CHILD'S NAME: _____ CHILD'S DOCTOR: _____ DATE: _____/_____/_____
MM DD YY

1. What would you like to discuss today?

_____

_____

2. What concerns or questions do you have about your baby?: (check all that apply)

- ☐ Eating too much or not enough
- ☐ Gaining too much weight or not enough weight
- ☐ I have no concerns
- ☐ Other, please list: _____

3. My baby has a: (check all that apply)

- ☐ Food allergy: _____
- ☐ Medical issue: _____
- ☐ Other, please list: _____
- ☐ None of the above

4. My baby currently takes: (check all that apply)

- ☐ Medicine: _____
- ☐ Vitamins or minerals: _____
- ☐ Herbal teas or products: _____
- ☐ Other, please list: _____
- ☐ None of the above

5. In the past month, my baby has had: (check all that apply)

- ☐ Diarrhea
- ☐ Constipation
- ☐ Vomiting, spitting up or reflux
- ☐ None of the above

6. Tell me how breastfeeding is going:

- ☐ Really well
- ☐ I could use some help/support
- ☐ I stopped breastfeeding
- ☐ I am not breastfeeding

7. My baby shows me they are hungry by:

_____

_____

8. My baby shows me they are full by:

_____

_____

9. Yesterday, my baby had: (list how many)

_____ wet diapers

_____ dirty diapers

10. Within the past six months, I worried that our food would run out before I had money to buy more.

- ☐ Never true
- ☐ Sometimes true
- ☐ Often true