Nutrition Questionnaire
6 months – 2 years

Patient Name ______________________________ Today's Date _______________

Date of Birth ______________________________ Patient Age _______________

Has you baby started solid foods? O Yes O No

If so, which ones? ____

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Is your child allergic to any food or drinks? O Yes O No

If yes, allergic reaction to what? ____

How do you react? O Rash O Swelling O Itching / Tingling (mouth, throat, ears)

O Difficulty breathing O Vomiting

Does your child take any vitamins/minerals or food supplements? O Yes O No

If yes, which ones? ____

Please estimate the percentage of milk that your child receives from:

Breastfeeding _____%

Expressed breast milk in a bottle _____%

Formula in a bottle _____%

Please estimate the how long it takes your baby to complete a feeding:

Breast ________________

Bottle ________________

How often does your baby eat (e.g. every 3 hours)?

Daytime ____

Overnight ____

Do you have any concerns about the way your baby eats? (e.g. frequency, amount, latch)

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