



PATIENT NAME _____ AGE _____ SEX _____ EXAM. DATE _____

Welcome to you and your child. Please answer these questions and provide further information in the column at the right.

(Please explain right-hand column answers here.)

- | | | |
|---|-----|-----|
| 1. Do you have any concerns about your child's health, growth, development, behaviors or language skills? | No | Yes |
| 2. Is your child breast-feeding? (How often per day? _____) | No | Yes |
| 3. Is your child taking a bottle? (How often per day? _____) | No | Yes |
| Ounces per day of Milk _____ Formula _____ Juice _____ | | |
| 4. Is your child taking solid foods and table foods well? | Yes | No |
| 5. Does your child sleep well at night? | Yes | No |
| 6. Does s/he have any habits? <input type="checkbox"/> blanket <input type="checkbox"/> thumb-sucking | No | Yes |
| <input type="checkbox"/> nail-biting <input type="checkbox"/> hair-pulling <input type="checkbox"/> other _____ | | |
| 7. Has your child had any serious injuries or health problems recently? | No | Yes |
| 8. Has s/he had any of the childhood diseases? | No | Yes |
| <input type="checkbox"/> Roseola <input type="checkbox"/> Hand-Foot-Mouth <input type="checkbox"/> Strep <input type="checkbox"/> Other | | |
| 9. Does your child have any allergies? _____ | No | Yes |
| 10. Does your child take any medications or supplements regularly? | No | Yes |
| <input type="checkbox"/> Vitamins <input type="checkbox"/> Fluoride Other: _____ | | |
| 11. Do you clean your child's teeth regularly? | Yes | No |
| 12. Would you like information about future dental consultation yet? | No | Yes |
| 13. Has your child ever been physically, mentally or sexually abused? | No | Yes |
| 14. Has the family had any stresses or illnesses recently? | No | Yes |
| 15. Is your child cared for by a babysitter or day care? | No | Yes |
| 16. Do you always use a properly installed car seat for your child? | Yes | No |
| 17. Do you have a working smoke alarm? | Yes | No |
| 18. Have you had formal CPR and First Aid training? | Yes | No |
| 19. Do you have poison control information's phone number at home? | Yes | No |
| 20. Is your child regularly exposed to cigarette or tobacco smoke? | No | Yes |
| 21. Do you have any questions about today's vaccines? | No | Yes |
| 22. Please review the <i>Lead Exposure Questionnaire</i> . Are any of those risk factors present for your child? | No | Yes |
| 23. Does your child: <input type="checkbox"/> Use a spoon <input type="checkbox"/> Remove a garment | Yes | No |
| <input type="checkbox"/> Point to named body parts <input type="checkbox"/> Stack 3 blocks | | |
| <input type="checkbox"/> Go up stairs with hand held <input type="checkbox"/> Help with simple tasks | | |
| <input type="checkbox"/> Use and understand 10 words <input type="checkbox"/> Run stiffly, kick a ball | | |
| 24. Are there any special questions you would like to ask today? | No | Yes |
| 1) | | |
| 2) | | |
| 3) | | |