



PATIENT NAME _____ AGE _____ SEX _____ EXAM. DATE _____

Welcome to you and your child.

(Please explain right-hand column answers here.)

- | | | |
|--|-----|-----|
| 1. Do you have any concerns about your child's happiness, growth, development, behaviors or language skills? | No | Yes |
| 2. Does your child have any chronic or recurrent health problems? | No | Yes |
| 3. Is your child taking a bottle? (How often per day?_____) | No | Yes |
| 4. Does your child drink milk? (How many ounces per day?_____) | Yes | No |
| 5. Is your child eating well? | Yes | No |
| 6. Does your child sleep well at night? | Yes | No |
| 7. Does s/he have any habits? (circle) blanket thumb sucking nail biting hair pulling other | No | Yes |
| 8. Has your child had any serious illnesses, injuries, hospitalizations or surgery? | No | Yes |
| 9. Has s/he had any of the childhood diseases? (Circle) Chicken Pox Hand-Foot-Mouth Strep Roseola Other | No | Yes |
| 10. Does your child have any allergies? _____ | No | Yes |
| 11. Does your child take any medications or supplements regularly? (Circle) Vitamins Fluoride Other:_____ | No | Yes |
| 12. Do you clean your child's teeth regularly? | Yes | No |
| 13. Has your child had a dental consultation yet? | Yes | No |
| 14. Has your child ever been physically, mentally or sexually abused? | No | Yes |
| 15. Has the family had any major changes or stresses recently? | No | Yes |
| 16. Is your child cared for by a babysitter or day care? | No | Yes |
| 17. Does everyone in the family use seat belts and car seats? | Yes | No |
| 18. Do you have a working smoke alarm? | Yes | No |
| 19. Have you had formal CPR and First Aid training? | Yes | No |
| 20. Do you have poison control information's phone number at home? | Yes | No |
| 21. Is your child regularly exposed to cigarette or tobacco smoke? | No | Yes |
| 22. Does your family have any risk factors for tuberculosis? (Check:) | No | Yes |
| <input type="checkbox"/> TB, AIDS or HIV in family <input type="checkbox"/> Lived outside USA in last year | | |
| <input type="checkbox"/> Exposure to homeless, prison or jail environments | | |
| 23. Does your child: <input type="checkbox"/> Say 20 words <input type="checkbox"/> Wash and dry hands | Yes | No |
| <input type="checkbox"/> Use 2-word phrases and plurals <input type="checkbox"/> Walk and run well | | |
| <input type="checkbox"/> Stack 6 to 8 blocks <input type="checkbox"/> Imitate adults | | |
| <input type="checkbox"/> Pedal a tricycle <input type="checkbox"/> Put on clothing | | |
| 24. Are there any special questions you would like to ask today? | No | Yes |
| 1) | | |
| 2) | | |
| 3) | | |