



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. Does your child drink milk? (How many ounces per day? _____) | Yes | No |
| 4. Is your child eating well? | Yes | No |
| 5. Does your child sleep well at night? | Yes | No |
| 6. Does s/he have any habits? (circle) blanket thumb sucking nail biting hair pulling other | No | Yes |
| 7. Has your child had any serious illnesses, injuries, hospitalizations or surgery? | No | Yes |
| 8. Has s/he had any of the childhood diseases? (Circle) Chicken Pox Roseola Scarlet Fever Hand-Foot-Mouth | No | Yes |
| 9. Does your child have any allergies? _____ | No | Yes |
| 10. Does your child take any medications or supplements regularly? (Circle) Vitamins Fluoride Other: _____ | No | Yes |
| 11. Do you clean your child's teeth regularly? | Yes | No |
| 12. Has your child had a dental consultation yet? | Yes | No |
| 13. Has your child ever been physically, mentally or sexually abused? | No | Yes |
| 14. Has your family had any major changes or stresses recently? | No | Yes |
| 15. Is your child cared for by a babysitter or day care? Does s/he enjoy it and do well there? | No | Yes |
| | Yes | No |
| 16. Does everyone in the family use seat belts and car seats? | 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. 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 | | |
| Exposure to homeless, prison or jail environments | | |
| 22. Does your child: <input type="checkbox"/> Make tower of more than six blocks | No | Yes |
| <input type="checkbox"/> Climb stairs, alternating feet <input type="checkbox"/> Understand on, in, under | | |
| <input type="checkbox"/> Separate easily from parents <input type="checkbox"/> Get dressed with supervision | | |
| 23. Are there any special questions you would like to ask today? | No | Yes |
| 1) | | |
| 2) | | |
| 3) | | |