



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 and sleeping well? | Yes | No |
| 5. Does s/he have any habits? <input type="checkbox"/> blanket <input type="checkbox"/> thumb sucking <input type="checkbox"/> nail biting
<input type="checkbox"/> bed wetting <input type="checkbox"/> other | No | Yes |
| 6. Has your child had any serious illnesses, injuries, hospitalizations or surgery? | No | Yes |
| 7. Has s/he had any of the childhood diseases? <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Roseola
<input type="checkbox"/> Hand-Foot-Mouth <input type="checkbox"/> Other | No | Yes |
| 8. Does your child have any allergies? _____ | No | Yes |
| 9. Does your child take any medications or supplements regularly?
<input type="checkbox"/> Vitamins <input type="checkbox"/> Fluoride <input type="checkbox"/> Other: _____ | No | Yes |
| 10. Do you brush and floss your child's teeth regularly? | Yes | No |
| 11. Does your child have regular dental checkups? | Yes | No |
| 12. Has your child ever been physically, mentally or sexually abused? | No | Yes |
| 13. Has the family had any major changes or stresses recently? | No | Yes |
| 14. Does your child attend day care, preschool, or school? | No | Yes |
| 15. Does your child have any special or unusual talents or abilities?
_____ | No | Yes |
| 16. Do you have any questions about the DTaP, Polio and MMR vaccines that are usually given just before starting kindergarten? | No | Yes |
| 17. Does everyone always use seat belts in the car? | 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:)
<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 | No | Yes |
| 23. Are there firearms in your household? | No | Yes |
| 24. Does your child: <input type="checkbox"/> Skip and hop <input type="checkbox"/> Enjoy telling stories
<input type="checkbox"/> Give first and last name <input type="checkbox"/> Dress without supervision | Yes | No |
| 25. Are there any special questions you would like to ask today?
1)
2)
3) | No | Yes |