**Parents Marital Status:**
- Married ______
- Single ______
- Widowed ______
- Divorced ______
- Living Together ______________
- Separated ____________________

**Parental involvement in child care:**
- Father Yes / No
- Mother Yes / No

**What language do you or your child best understand**
- ____________________________________________

**Who lives in the household**
- ____________________________________________

**Family Physician or Pediatrician:**
- ____________________________________________

**How do you or your child best learn:**
- a. One on One Instruction _____
- b. Audio Visual Information _____
- c. Written Information ______
- d. Group Instruction _____
- e. Demonstration/Practice _____
- f. Other ______________________________________

**Is your child exposed to anyone who uses tobacco?**
- Yes / No
- Who? ________________________________

**Does anyone in the household consume alcohol?**
- Yes / No

**Does anyone in the household use any other substances**
- Yes / No
- If yes, type_________________________

**Is your child afraid of anyone?**
- Yes / No

**Has your child ever been physically or emotionally hurt by anyone?**
- Yes / No

**Are there pets in the household?**
- Yes / No
- Type:________________________________________________

**Water type?**
- City / Well

**School District**
- ________________________________

**School Concerns:**
- Yes / No

**Does your child wear a bike helmet?**
- Yes / No

**Does your child use a car seat, booster seat, or seat belt?**
- Yes / No

**Do you or your child have any special needs we should be aware of so that we can better serve you?**
- ____________________________________________

---

**Updated**
- ________________________________

**Reviewed By**
- ________________________________
Has the patient ever had or experienced any of the following:

<table>
<thead>
<tr>
<th>General</th>
<th>GI</th>
<th>GU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss</td>
<td>Difficulty swallowing</td>
<td>Painful voiding/urinating</td>
</tr>
<tr>
<td>Weight gain</td>
<td>Diarrhea</td>
<td>Bed wetting</td>
</tr>
<tr>
<td>Eyes</td>
<td>Reflux</td>
<td>Urinary tract infection</td>
</tr>
<tr>
<td>Glasses/Contact</td>
<td>Blood in stool</td>
<td>Toilet trained</td>
</tr>
<tr>
<td>ENT</td>
<td>Constipation</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Heart murmur</td>
<td>Scoliosis</td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td>Integumentary</td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Rashes</td>
<td></td>
</tr>
<tr>
<td>Fainting</td>
<td>Seizures</td>
<td></td>
</tr>
<tr>
<td>Asthma/wheezing</td>
<td>Hydrocephalus</td>
<td></td>
</tr>
<tr>
<td>Bronchitis/Pneumonia</td>
<td>Developmental Delay</td>
<td></td>
</tr>
<tr>
<td>Sleep Apnea</td>
<td>Cerebral Palsy</td>
<td></td>
</tr>
<tr>
<td>Home oxygen therapy</td>
<td>Numbness arms/legs</td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>Unsteady gait</td>
<td></td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>Difficulty speaking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Headaches</td>
<td></td>
</tr>
</tbody>
</table>

Family Medical History:

<table>
<thead>
<tr>
<th>Diabetes</th>
<th>Stroke</th>
<th>Childhood Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Anemia</td>
<td></td>
</tr>
<tr>
<td>Anesthesia Complications</td>
<td>Blood/Bleeding Disorders</td>
<td></td>
</tr>
</tbody>
</table>

Does your child have allergies? Yes / No If yes, please list:

- Medications:
- Environmental:

Immunizations up to date □ Yes □ No

Signature of person who reviewed and discussed above with the provider. Date Time