Health History (Age: 0 – 4 yrs)

Intake

Name of Patient: _____

Date of Birth: _____

Today's Date: _____

Social History:
Please check appropriate box and/or answer questions to the best of your ability.

Questions:

1. Diet: ___Regular ___Vegetarian ___Vegan ___Gluten Free
   ___Other please specify: _____
2. Exercise Level: ___None ___Occasional ___Moderate ___Heavy
3. Sporting Activities: _____
4. Parents' Marital Status: ___Married ___Unmarried ___Separated ___Divorced ___Widowed
5. Home Situation: ___Both Parents ___Mother ___Father ___Relatives ___Adoptive Parents
   ___Foster Parents ___Other Please Specify: _____
6. Siblings: _____
7. Childcare: ___None ___Relative ___Private Sitter ___Daycare/Preschool
8. Animal Exposure: ___Yes ___No
9. Passive Smoke Exposure ___Yes ___No
10. Seat belt/Car seat used routinely: ___Yes ___No
11. Sunscreen used routinely: ___Yes ___No
12. Guns present in home: ___Yes ___No
13. Smoke Alarm in home: ___Yes ___No