

**Health History (Age: 5 – 12 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. Animal Exposure:  Yes  No
8. Passive Smoke Exposure  Yes  No
9. Seat belt/Car seat used routinely:  Yes  No
10. Sunscreen used routinely:  Yes  No
11. Guns present in home:  Yes  No
12. Year in School (current grade): \_\_\_\_\_
13. Smoke Alarm in home:  Yes  No