



Parent Questionnaire for Patients (Ages 0-11 months)

Name:	Acct. No:
Age:	DOB:
Phone:	PC:
Date:	Clinician:

Parent questionnaire – Please take the time to answer the following questions in order for us to better care for your child.

		Please Circle Answer		Counseled/Referred
Health	Does your child have any food, medication, or environmental allergies?	No	Yes	
	Has your child required surgery, hospitalization, ER or urgent care visit since his/her last checkup? Please circle	No	Yes	
	Have there been any changes in a family member's health since your last visit (i.e. new onset diabetes, high cholesterol, unhealthy weight, etc)?	No	Yes	
	Do you have any concerns about your child's height, weight, or development (including language, vision, or hearing)? Please circle	No	Yes	
	Do you have well water and/or a reverse osmosis filter?	No	Yes	
	Do you supplement your child with vitamin D or any other supplements?	Yes	No	
Social	Has there been a major change in your life recently due to moving, divorce, remarriage, new job, illness or other stressor? Please circle	No	Yes	
	Does your child attend daycare?	No	Yes	
	Do you often feel stressed, anxious or angry?	No	Yes	
	Do you have any concerns regarding the use of alcohol or drugs by anyone in your family or by anyone caring for your child?	No	Yes	
Safety	Have you or any of your children ever been hurt, yelled at, threatened, or treated badly?	No	Yes	
	Do you keep handguns, rifles, BB guns, bow and arrows or other weapons in your home? Please circle.	No	Yes	
	Do you have working smoke and carbon monoxide detectors in your home?	Yes	No	
	What kind of carseat does your child sit in? Please circle 1. Infant or Child 2. Rear facing or Forward facing			
	Do you offer your baby a pacifier at nap time and/or at night?	Yes	No	
	Does your child sleep on his/her back?	Yes	No	
	Do you want information on baby proofing your home?	No	Yes	

Questions reviewed and safety/anticipatory guidance provided to family.