



Scan this code for age specific health information

Date:

★ **Do you have any concerns about your child's:**

No | Yes vision? No | Yes hearing?

★ **Does your child:**

No | Yes eat fast food more than once a week? No | Yes get less than 1 hour of active play per day?

★ **Do you:**

Yes No take your child to the dentist each year?	Yes No know CPR & the rescue maneuver for choking?
Yes No have your child brush their teeth daily?	Yes No put sunscreen on your child?
Yes No always use a car seat? (5-point harness, in the backseat)	Yes No avoid foods that can cause your child to choke? (hot dogs, peanuts, popcorn, raw carrots, hard candy)
Yes No have working smoke alarms and carbon monoxide detectors in your home?	Yes No If you own a gun, is it locked, with bullets stored separately? <input type="checkbox"/> No gun in home

★ **Family Medical History**

No Yes Have there been any changes to your family medical history?	No Yes Is there a family history of early heart disease? (under age 65 for women, age 55 for men)
No Yes Does your child have a parent with total cholesterol over 240 mg/dL?	

★ **Tuberculosis (TB) Risk**

No Yes Has your child had recent close contact with someone with active TB disease?	No Yes Was your child born in or had extensive travel to Asia, Africa, Eastern Europe or Latin America?
No Yes Does your child have any chronic illnesses (including HIV, diabetes, cancer, kidney disease, intestinal disease)?	No Yes Has your child been exposed to homeless shelters, refugee camps or prison/jail?

★ **Social Determinants of Health**

In the past 12 months, has lack of transportation kept you from medical appointments, meetings, working or from getting things needed for daily living? *(check all that apply)* Z59.82

- Yes, it has kept me from medical appointments or getting medication
- Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need
- No

Would you like information regarding these concerns? *(check all that apply)*

- Yes, have someone contact me Yes, I would like written information No

★ **Please write down any questions or concerns that you would like to talk about today:**

Name: _____

Birthdate: _____

_____ Provider initials