

If both parents work, who provides child care? Day Care Center Sitter in the Home Relative Other _____

Are there any family members living with the child who smoke? Yes No

What type of water is used in the home? City Well

Does the patient use tobacco? No Yes If yes, how much/day? _____ How many years? _____

Does the patient use recreational drugs? No Yes If yes, what type? _____ How long? _____

Does the patient use alcohol? No Yes If yes, how much per day? _____ Per week? _____ How long? _____

Does the patient use caffeine? No Yes If yes, how much per day? _____ How long? _____

Is the patient sexually active? No Yes If yes, how long? _____

Unusual dietary habits: _____ Special Interests: _____

Have you had a family member with any of the following? If so, check the appropriate box and write the family member.

Asthma _____

Febrile Seizures _____

Bleeding Disorders _____

Emphysema _____

Thyroid Disease _____

SIDS (crib death) _____

Epilepsy _____

Heart Diseases/Attack _____

High Blood Pressure _____

Diabetes _____

Mental Retardation _____

High Cholesterol _____

Tuberculosis _____

Genetic Disease _____

Other _____

Stroke _____

Cancer (include type) _____

Signature: _____ Relationship to patient: _____ Date: _____