KIDS FIRST PEDIATRICS, PC

Port Jefferson Station (631) 331-7267 Fax (631) 331-7289 Wading River (631) 929-0325 Fax (631) 929-0360

PATIENT DATA:

Patient Name		Date of Birth		Age	
Phone	H / W	Phone	H / W		

Date of Encounter _____ **HISTORIAN:** __ mom __ dad __ other _____

INJURY PREVENTION

Do you practice FIRE SAFETY with your child?

Occasionally Once Never

Do you encourage your child to wear a SAFETY HELMET when riding a bicycle, scooter, skate board, roller skates, etc?

Always Depends on what they're riding Never

Do you encourage your child to LOOK BOTH WAYS when crossing a street?

Always Sometimes Never

Do you encourage your child to cross the street at the designated CROSSWALKS?

Always Sometimes Never

Do you encourage your child to use a BOOSTER SEAT?

Always Depends on who's driving Never

ASSESMENT & GUIDANCE

How often does your child eat "fast food"?

Never Occasionally Weekly or More

Does your child SKIP meals? (If 'YES,' circle all that apply)

No Skips Breakfast Skips Lunch Skips Dinner

How often does your child EXERCISE (run around outside, participate in organized sports)?

Daily Weekly Never

On a daily basis, HOW MANY hours does your child WATCH TV (play video games, spend time in front of a PC, etc)?

1 to 2 2 to 3 3 to 4

Do you think your child's WEIGHT is appropriate for her / his age?

Yes No Don't Know

How often does your child get into PHYSICAL FIGHTS with siblings, friends, schoolmates?

Never Weekly Daily

Do you feel your child has persistent NEGATIVE FEELING about themselves?

No Yes Don't Know

Do you feel your child has a PROBLEMS SLEEPING (fatigue upon arising, wrestles sleep, napping during the day)?

Never Weekly Daily

Does anyone in mom or dad's family have:

DIABETES	No	Yes	Don't Know
HYPERTENSION	No	Yes	Don't Know
HIGH CHOLESTEROL / TRIGLYCERIDES	No	Yes	Don't Know
HEART DISEASE	No	Yes	Don't Know

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