

PATIENT NAME _____

DOB: _____

① Does your child / teenager have any siblings? ☐ Yes ☐ No

④ Do you have any pets? ☐ Yes ☐ No

② Does anyone smoke at home? ☐ Yes ☐ No

⑤ Are there any guns in the home? ☐ Yes ☐ No

③ Are guns locked and kept separate from ammunition? ☐ Yes ☐ No

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[illegible]