## Well Child Check: 6 year visit questionnaire

### Interval History:

Has your child had any major illnesses, ER or Urgent Care trips since your last appointment in the office?  
- Yes  
- No

Has your child had any reactions to vaccinations in the past?  
- Yes  
- No

### School/Activities:

What grade level is your child in school? 

What activities does your child participate in (music/arts/sports/other)?

### Development:

Does your child know left from right?  
- Yes  
- No

Is your child’s speech clear (little/no difficulty understanding what your child says)?  
- Yes  
- No

Can your child write legibly?  
- Yes  
- No

Does your child have good hand-eye coordination?  
- Yes  
- No

Do you have any concerns about your child’s interaction with peers at school?  
- Yes  
- No

Does your child play cooperatively with other children?  
- Yes  
- No

Is your child doing grade-level work at school?  
- Yes  
- No

Is your child toilet trained daytime and nighttime?  
- Yes  
- No

Does your child read for pleasure?  
- Yes  
- No

Do you have any concerns about how your child hears or speaks?  
- No  
- Yes

Do you have any concerns about how your child sees?  
- No  
- Yes

### Dental Health:

Does your child have a dentist?  
- Yes  
- No

Does your child’s primary water source contain fluoride?  
- Yes  
- No  
- Unsure

If no, do you give your child a fluoride supplement?  
- Yes  
- No  
- N/A

Does your child brush and floss her/his teeth daily?  
- Yes  
- No
Staying Healthy/Safety/Tobacco Exposure:

Does your child watch TV, play video games or use a computer, tablet or smart phone more than 2 hours per day? No Yes

Is there a television or computer in your child’s bedroom? No Yes

Do you monitor your child’s television and internet use? Yes No

Does your home have a working smoke detector? Yes No

Have you turned your water temperature down to low-warm (less than 120 degrees)? Yes No N/A

Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone? Yes No

Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4’ 9”)? Yes No

Does your child spend time near water (swimming pool, river or lake)? No Yes

If so, is your child always safely supervised? Yes No N/A

and learning (or already know) how to swim? Yes No N/A

Do you use sunscreen when your child is outdoors? Yes No

Does your child spend time in a home where a gun is kept? No Yes Skip

If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun? Yes No N/A

Does your child spend time with anyone who carries a gun, knife, or other weapon? No Yes Skip

If so, is the weapon safely stored and inaccessible to your child? Yes No N/A

Have you discussed stranger awareness with your child? Yes No

Does your child wear a helmet when riding a bike, skateboard or scooter? Yes No N/A

Has your child ever witnessed or been a victim of abuse or violence? No Yes

Has your child been hit, or hit someone in the past year, other than occasional sibling or friend roughness? No Yes

Has your child ever been bullied or felt unsafe at school or in your neighborhood? No Yes

Does your child often seem sad or depressed? No Yes

Do you have concerns about your child’s relationship with parents or siblings? No Yes

Do you have concerns about how to discipline/set appropriate limits for your child? No Yes
Does your child spend time with anyone who smokes?  

**Tuberculosis Screening:**

Was your child born in a country with an elevated TB rate?  
This includes all countries **other than** the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.

Has your child visited or lived in a country with an elevated TB rate **for one month or more**? (Countries other than those listed above)

Has your child had contact with someone (including family member, childcare provider, or other caretaker) with known TB infection, or who has been treated for TB infection?

Is your child immunosuppressed (currently or planned)?  
This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

**Risk Assessment for Abnormal Lipid Profile (such as high cholesterol):**

Did any of your child’s parents or grandparents have significant heart disease at or before 55 years of age (heart attack, stroke, angioplasty, angina or bypass surgery)?

If yes, who? at what age?

Do either of the child’s parents have a cholesterol of 240 or higher?

If yes, who? How high (before treatment)?

**Sleep:**

How many hours does your child sleep at night?

Are you satisfied with your child’s sleep?

Does your child snore on a regular basis?

**Nutrition/Physical Activity:**

What type of milk do you give your child? (circle one)  

How many ounces of milk does your child drink per day?

How much juice does your child drink in 24 hours?

Is your child eating fruits and vegetables at least two times per day?

Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, soy milk, cheese, yogurt, or tofu?

Does your child eat junk foods such as chips, fries, ice cream or fast food more than twice per week?
Does your child drink soda, sports drinks, energy drinks or other sweetened drinks more than once per week?  
No  Yes

Does your child eat iron rich foods (such as meat, eggs, iron-fortified cereals or beans)?  
Yes  No

Does your child eat a strict vegetarian diet?  
No  Yes

If your child is a vegetarian, does he/she take an iron supplement?  
Yes  No  N/A

Does your child exercise or play sports most days of the week?  
Yes  No

Do you have any concerns about your child’s weight or diet?  
No  Yes

**Elimination:**

Does your child have bowel movements on a regular basis with a normal (soft) consistency?  
Yes  No

Please list any medications or supplements your child is taking:

Who lives in the home with your child?  

Please list any new major family medical issues:

Please list any known allergies to medicines:

Please list any known food allergies:

Do you have any concerns about your child’s development, or any other concern you would like to discuss with your provider?

**Parent or Guardian Signature:**

Date:  

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PCP’s Signature  

Print Name:  

Date:  

[ ] Patient Declined the SHA

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