Well Child Check: 7 year visit questionnaire

Interval History:
Has your child had any major illnesses, ER or Urgent Care trips since your last appointment in the office? No Yes
Has your child had any reactions to vaccinations in the past? No Yes

School/Activities:
What grade level is your child in school? ____________
What activities does your child participate in (music/arts/sports/other)? ________________

Vision/Hearing and Development:
Do you have concerns about how your child sees? Yes No
Has your child ever failed a school vision screening test? Yes No
Do you have concerns about how your child hears or speaks? 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
Does your child read for pleasure? Yes No
Does your child help with chores around the house? Yes No

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? Yes No
Is there a television or computer in your child’s bedroom? Yes No
Do you monitor your child’s television and internet use? Yes No
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Does your home have a working smoke detector?</td>
<td>Yes</td>
<td>No</td>
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<td>Have you turned your water temperature down to low-warm (less than 120 degrees)?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?</td>
<td>Yes</td>
<td>No</td>
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<td>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”)?</td>
<td>Yes</td>
<td>No</td>
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<td>Does your child spend time near water (a swimming pool, river or lake)?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
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<td>If so, is your child always safely supervised? and learning (or already knows) how to swim?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>Do you use sunscreen when your child is outdoors?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>Does your child spend time in a home where a gun is kept?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
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<td>If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>Does your child spend time with anyone who carries a gun, knife, or other weapon?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
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<td>If so, is the weapon safely stored and inaccessible to your child?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>Have you discussed stranger awareness with your child?</td>
<td>Yes</td>
<td>No</td>
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<td>Does your child wear a helmet when riding a bike, skateboard or scooter?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>Has your child ever witnessed or been a victim of abuse or violence?</td>
<td>No</td>
<td>Yes</td>
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<td>Has your child been hit, or hit someone in the past year, other than occasional sibling or friend roughness?</td>
<td>No</td>
<td>Yes</td>
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<td>Has your child ever been bullied or felt unsafe at school or in your neighborhood? (been cyber-bullied?)</td>
<td>No</td>
<td>Yes</td>
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<td>Does your child often seem sad or depressed?</td>
<td>No</td>
<td>Yes</td>
<td></td>
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<td>Do you have concerns about your child’s relationship with parents or siblings?</td>
<td>No</td>
<td>Yes</td>
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<td>Do you have concerns about how to discipline/set appropriate limits for your child?</td>
<td>No</td>
<td>Yes</td>
<td></td>
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<td>Does your child spend time with anyone who smokes?</td>
<td>No</td>
<td>Yes</td>
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Tuberculosis Screening:

Was your child born in a country with an elevated TB rate? No Yes

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? No Yes

(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? No Yes Unsure

Is your child immunosuppressed (currently or planned)? No Yes

This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

Sleep:

How many hours does your child sleep at night? _____ hours

Are you satisfied with your child’s sleep? Yes No

Does your child snore on a regular basis? No Yes

Nutrition/Physical Activity:

What type of milk do you give your child? (circle one) [Whole] [2%] [Nonfat] [Other] [None]

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

How much juice does your child drink in 24 hours? _____ oz

Is your child eating fruits and vegetables at least two times per day? Yes No

Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, soy milk, cheese, yogurt, or tofu? Yes No

Does your child eat junk foods such as chips, fries, ice cream or fast food more than twice per week? No Yes

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?  

**Elimination:**  
Does your child have bowel movements on a regular basis with a normal (soft) consistency?  

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<th>Yes</th>
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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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<th>Clinic Use Only</th>
<th>Counselled</th>
<th>Referred</th>
<th>Anticipatory Guidance</th>
<th>Follow-up Ordered</th>
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[Patient Declined the SHA]

PCP’s Signature  

Print Name:  

Date: __________

Ver.12-12-17