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?  No  Yes
Has your child ever failed a school vision screening test?  No  Yes
Do you have concerns about how your child hears or speaks?  No  Yes
Does your child have good hand-eye coordination?  Yes  No
Do you have any concerns about your child’s interaction with peers at school?  No  Yes
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?  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 (a swimming pool, river or lake)?  No  Yes  Skip

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

and learning (or already knows) 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?  No  Yes

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

**Tuberculosis Screening:**
Has a family member or contact had tuberculosis or a positive
tuberculin skin test (PPD)?  No  Yes  Unsure

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Was your child born in a high risk country (countries other than the US, Canada, Australia, New Zealand or Western Europe)?  No Yes

Has your child traveled to (or had contact with people who live in a high risk country) for more than one week? (Countries other than the US, Canada, Australia, New Zealand or Western Europe)  No Yes

**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 high fat foods such as fried foods, chips, ice cream or pizza more than once 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?  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?

_______________________________________________________________________________________

Signature: ________________________________ Date: ____________________

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☐ Patient Declined the SHA

PCP’s Signature  Print Name:  Date:

Ver.5-7-15