

Lucile Salter Packard Children's Hospital

STANFORD UNIVERSITY MEDICAL CENTER ● 725 Welch Road, Palo Alto, CA 94304



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Patient Name

Date of Birth

Well Child Check: 6 year visit questionnaire

Interval History:					
Has your child had any major illnesses or doctor visits since last seen here	? No	Yes			
<u>Development:</u> Does your child (check all that apply) –					
speak clearly?	_ bike withou	bike without training wheels?			
have good hand-eye coordination?	have good hand-eye coordination? swim independently?				
know left from right? interact well with others?					
read for pleasure?	_ stay dry all	stay dry all night?			
School/Activities:					
What grade level is your child in school? Where? _					
Other activities (music/arts/sports/other)?					
Is your child performing at grade level?	Yes	No			
Does your child write legibly?	Yes	No			
What are your child's interests and goals?					
Nutrition/Elimination/Physical Activity:					
What type of milk does your child drink? How m	uch per day?		_ cups		
How much yogurt per day? How much cheese per					
What dietary restrictions does your child have, if any?					
How much juice and sweet beverages does your child drink in a day?		_ oz			
Is your child eating at least 4 servings per day of fruits and vegetables?	Yes	No			
Does your child eat junk food and/or fast food more than twice per week?	No	Yes			
Does your child eat iron rich foods (meat, iron-fortified cereals, or beans)?	Yes	No			
If your child is vegetarian, does he/she take an iron supplement?	Yes	No	N/A		
Are there any problems with pooping or peeing?	No	Yes			
Does your child exercise or play sports most days of the week?	Yes	No			
Dental Health:					
Does your child see a dentist every 6 months?	Yes	No			
Does your child (with your help) brush her/his teeth daily?	Yes	No			
Sleep:					
How many hours does your child sleep at night?		_ hours			
Does your child snore on a regular basis?	No	Yes			
Staying Healthy and Safe:					
Does your child get screen time 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			
Is your child always in a car seat or booster seat in the back seat?	Yes	No			



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Questionnaire • Well Child Check 6 Years

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Is your child always supervised when near water and also learning to swim?	Yes	No	
Does your child use sun protection when outdoors?	Yes	No	
Does your child wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	N/A
Is there a gun at home?	No	Yes	- "
If yes: Is the gun locked?	Yes	No	
Is ammunition stored separately?	Yes	No	
If your child spends time with anyone who owns a gun/knife/other weapon, is the weapon safely stored and inaccessible to your child?	Yes	No	N/A
Have you discussed stranger awareness and personal safety with your child?	Yes	No	
Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	
Has your child seriously injured or been seriously injured in the past year?	No	Yes	
Has your child ever bullied or been bullied at school/home/neighborhood?	No	Yes	
Does your child often seem sad or depressed?	No	Yes	
Are you concerned about your child's relationship with parents/siblings?	No	Yes	
Do you have concerns about how to set appropriate limits for your child?	No	Yes	
Does your child spend time with anyone who smokes or vapes?	No	Yes	
Please list your child's medications/supplements: Please list any new major family medical issues:			
Who lives in the home with your child?			
What international travel has your child had since their last well check? (where	e and hov	v long)	
What plans are there for international travel with your child in the next 12 mor	nths? (wh	ere and	how long)
What concerns would you like to discuss today?			

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