Patient Name

Date of Birth

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? 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)?____

____

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? No ☐ Yes ☐

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 ☐

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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? No ☐ Yes ☐

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***? (Countries other than those listed above) No ☐ Yes ☐

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.

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)? No ☐ Yes ☐

If yes, who? ______________________________________ __________at what age? ____________________

Do either of the child's parents have a cholesterol of 240 or higher? No ☐ Yes ☐

If yes, who? ____________________________________How high? (before treatment) ____________________

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 ☐

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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: ____________________

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	**☐ Patient Declined the SHA**
PCP's Signature		Print Name:			Date: