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## 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)? \_\_\_\_\_

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### 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

**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

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: \_\_\_\_\_

<i><b>Clinic Use Only</b></i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div style="border: 2px solid black; padding: 5px;"><input type="checkbox"/> <b>Patient Declined the SHA</b></div>
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature		Print Name:		Date:	