Medical Record Number

Patient Name

Patient Label

Well Child Check: 9-11 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)? _____

For Girls Only:

Has your daughter had her first period?	No	Yes	
If yes, do you or she have any questions about her periods?	No	Yes	N/A

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
Do you have any concerns about your child's interaction with peers at school?	No	Yes
Does your child have friends at school?	Yes	No
Does your child have good physical coordination overall?	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

Physical Activity:

Does your child exercise or play sports most days of the week?	Yes	No
Does your child have any chest pain with exercise?	No	Yes
Has your child had a major sports related injury or concussion?	No	Yes

Dental Health:

Does your child brush and floss his/her teeth daily?	Yes	No
Does your child see a dentist?	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 total per day (not including school work)?	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	
Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	
Does your child know how to use 911 in an emergency?	Yes	No	
Do you always use a seat belt in the back seat (or use a booster if if your child is under 4' 9")?	Yes	No	
Does your child spend time near water (a swimming pool, river or lake)?	No	Yes	
If so, is your child always safely supervised; and also able to swim?	Yes	No	N/A
Do you use sunscreen/hat/other sun protection measures 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? (or 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

Has your child ever smoked cigarettes or chewed tobacco? No Yes

Are you concerned that your child may be using drugs or sniffing substances such as glue to get high? No Yes

Are you concerned that your child may be drinking alcohol such as beer, wine coolers, wine or liquor? No Yes

Does your child have friends or family members who have a problem with drugs or alcohol? No Yes

Has your child started dating or "going out" with boyfriends or girlfriends? No Yes

Do you think your child might be sexually active? 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.

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:

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

Do you have any concerns about your child's weight? 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:

Ver.12-12-17