Patient Name:

Date of Birth:

Well Child Check: 9-11 year visit questionnaire

Interval History:

Has your child had any major illnesses or doctor visits since last seen here? No ☐ Yes ☐

Vision/Hearing and Development:

Has your child ever failed a school vision screening test? No ☐ Yes ☐
Do you have concerns about how your child sees, hears, or speaks? No ☐ Yes ☐
Have you talked to your child about puberty? Yes ☐ No ☐
Are you concerned 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 ☐
Does your child read for pleasure? Yes ☐ No ☐
Does your child help with chores around the house? Yes ☐ No ☐
Do you spend quality time together as a family? Yes ☐ No ☐

School/Activities:

What grade level is your child in school? _____ Where? _____
Other activities (music/arts/sports/other)? _____
Is your child doing grade-level work at school? Yes ☐ No ☐
What are your child's interests and goals? _____

Physical Activity:

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

Nutrition/Elimination:

What type of milk does your child drink? _____ How much per day? _____ cups
How much yogurt per day? _____ How much cheese per day? _____
What dietary restrictions does your child have, if any? _____
How much juice or other sweet beverages does your child drink in a day? _____ oz
Is your child eating at least 5 servings of fruits and vegetables per day? Yes ☐ No ☐
Does your child eat junk 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 ☐

Dental Health:

Does your child brush his/her teeth daily? Yes ☐ No ☐
Does your child see a dentist every 6 months? Yes ☐ No ☐

Sleep:

How many hours does your child sleep at night? _____ hours
Does your child snore on a regular basis? No ☐ Yes ☐

Patient Name:

Date of Birth:

Staying Healthy and Safe:

Does he/she get more than 2 hours daily of screen time (NOT school related)?	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 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 under 4' 9")?	Yes ☐	No ☐	
Is your child always supervised when near water and also able to swim?	Yes ☐	No ☐	
Does he/she use sun protection measures when outdoors?	Yes ☐	No ☐	
Is there a gun at home?	No ☐	Yes ☐	
If yes: Is the gun locked?	Yes ☐	No ☐	
Is the 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 ☐	
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 seriously injured another person or been seriously injured in the past year?	No ☐	Yes ☐	
Has your child ever bullied or been bullied (including cyber-bullied)?	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 ☐	
Has your child ever smoked cigarettes, chewed tobacco, or vaped?	No ☐	Yes ☐	
Are you concerned that your child is drinking alcohol, smoking, or abusing drugs (over-the-counter, prescription, sniffing glue)?	No ☐	Yes ☐	
Does your child have friends or family members who have a problem with drugs or alcohol?	No ☐	Yes ☐	

Please list your child's medications or 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 and how long)

_____

What plans are there for international travel with your child in the next 12 months? (where and how long)

_____

What concerns would you like to discuss today?

_____