Office Use Only

VFC: [ ] V02 -- MDD
[ ] V03 – No Ins
[ ] V04 -- Native
[ ] V07 -- AVAP

INSURANCE:

Copay / Co-ins

Statement Balance

3 Year Well Child Questionnaire

Note that "well child visits" are a form of preventative medicine, meant to catch any potential problems in a child's physical or developmental health. Each exam is tailored to the child's age, and may include necessary immunizations, vision, hearing, and developmental screenings. *If your child requires significant medical intervention or you request noteworthy management changes to existing chronic problems during this appointment, this may go above and beyond a preventative exam and must be coded and billed accordingly with your insurance, in which case your financial responsibility may also change.*

Office Use Only

WT: _____kg
WT: _____lb
HT: _____
OFC:_____
Temp: _____
Resp: _____
Pulse: _____
Oxygen: _____
BP: _____
Vision: L_____
R_____

Child's Name: _____Birth Date: _____

Who is your child's primary care physician? _____
Do you have any concerns about your child today?_____

Any allergies to medicines, foods, latex, etc.? Yes / No. Which ones? _____
Has your child had any difficulty with past immunizations? Yes / No. If yes, which ones? _____
Has your child had any surgeries? Yes / No. If yes, describe: _____
Has your child been hospitalized overnight? Yes / No. Is yes, why: _____
Is your child on any medicine/vitamins? Yes / No. Which ones/dose? _____

Health:

Is your child exhibiting any of the following symptoms?

Ear Pain / Ear Pulling	Yes / No. If yes, how long _____	Fever	Yes / No. If yes, how long _____
Ear Drainage	Yes / No. If yes, how long _____	Cough	Yes / No. If yes, how long _____
Eye Drainage	Yes / No. If yes, how long _____	Diarrhea	Yes / No. If yes, how long _____
Decreased Appetite	Yes / No. If yes, how long _____	Vomiting	Yes / No. If yes, how long _____
Constipation / Gas	Yes / No. If yes, how long _____	Rash	Yes / No. If yes, how long _____
Urinary Symptoms	Yes / No. If yes, how long _____	Sleep Problems	Yes / No. If yes, how long_ _____

Nutrition:

Dairy use? Circle one: Whole milk 2% 1% Skim Soy Ounces per day:_____
If 8 oz milk, 8 oz yogurt, or 1½ oz cheese equal 1 serving of dairy, how many total servings of dairy does your child consume each day? _____ # of meals / day_____ # of snacks / day _____
Does your child eat a reasonable amount and variety of table foods? Yes / No.
Does your child eat any of the following (please circle): Cereal | Vegetables | Fruits | Meat | Pasta | Fish
Circle your child's water supply source: City Bottled Well. Is your child on a cup AND off the bottle? Yes / No.
Can your child use an open cup? Yes / No. Does your child use a pacifier? Yes / No.
How many ounces of juice, soda and other sugar-sweetened beverages does your child consume each day? _____

Sleep and Elimination:

How many hours straight does your child sleep at night? _____
Does your child nap daily? Yes / No. If yes, how often and how long? _____
Is your child toilet trained? Yes / No / Attempting Any issues with training? _____
Does your child have any problems with urinating? Yes / No. Any problems with stooling? Yes / No. # of stools / day_____

Social:

Any changes in your child's environment? (new home, pets, daycare, etc.)_____
Is this child yours by: __ birth __ adoption __ marriage (stepchild) other _____
Who lives in the household with the child? (Please list for all households if more than one) **Please specify relationship to child**
_____
Marital status of Parents: __ married __ unmarried __ separated __ divorced __living together __ other: _____
Does this child live with you full-time? ____ Other? (Please describe)_____
Who is the primary caretaker? _____ Name of Dentist:_____
Does anyone in the household(s) smoke (inside or outside)? Yes / No. If yes, who? _____
Is Mom working? Yes / No. Full time / Part Time Occupation/place of work: _____
Is Dad working? Yes / No. Full time / Part Time Occupation/place of work: _____
Is your child in daycare or preschool? Yes / No. If yes, where? _____
Any pets? Yes / No. If yes, which kind? _____
Any food allergies in your family? Yes / No. If yes, who and to what? _____
Any seasonal allergies or asthma in your family? Yes / No. If yes, who and to what? _____

This form completed by: _____ Relationship to Child: _____ Today's Date_____

Updated 11/16/16