Office Use Only

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

INSURANCE:

Copay / Co-ins

Statement Balance

6-12 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 may 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: _____

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 _____

Does your child have 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: _____
Does your child have any chronic medical problems? _____
Is your child on any medicine/ vitamins? Yes / No. Which ones/dose? _____

Nutrition:

(Circle): Whole milk 2% 1% Skim Soy Other: _____| How many total ounces of **milk** does your child consume per day? ____
If 8 oz yogurt, or 1½ oz cheese equal 1 serving of dairy, how many total servings of dairy products 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.
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 have any problems with: Sleep? Yes / No. Urinating? Yes / No. Stooling? Yes / No # of stools / day_____

Education/Activities:

Which school does your child attend? _____
Grade Level: _____ Academic performance: _____
Behavior: _____ Teacher feedback: _____
Is your child in any special education classes or programs? Please specify: _____
Is your child in any therapies? Please specify: _____
Extracurricular activities: _____
Hobbies/ Interests: _____
How much vigorous physical exercise does your child get each 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 in the home? _____
Does anyone in the household 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? Yes / No. If yes, where/who? _____

CONTINUE TO OTHER SIDE

Do you have any pets in your home? Yes / No. Which kind/how many? _____
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? _____
Name of dentist: _____
Name of eye doctor: _____

The following questions are asked to assess any risk factors that may interfere with participation in PE/sports and camp.
Please answer them even if your child is not participating.

Has your child ever:

Broken any bones? Yes / No. If yes, which one(s) and at what age? _____
Passed out? Yes / No.
Had a seizure or convulsion? Yes / No.
Had a head injury / concussion? Yes / No.
Had numbness, tingling or weakness in the arms or legs after an injury? Yes / No.
Been hospitalized overnight? Yes / No.
Had wheezing, asthma, shortness of breath, or used an inhaler? Yes / No.
Coughed with exercise? Yes / No.
Complained of chest pain with exercise that interfered with activity? Yes / No.
Had a racing heart or skipped heartbeats? Yes / No.
Had severe, frequent headaches with exercise? Yes / No.
Had severe, recurrent muscle cramps while exercising? Yes / No.
Expressed concern about his/her weight? Yes / No.
Been denied participation in sports by a doctor for any reason? Yes / No.

Has anyone in your child's family died of heart problems or a sudden death before age 50? Yes / No. If yes, please list the relationship of the family member to the child: _____

FOR GIRLS ONLY:

My periods started when I was _____ years old.
Last period was: _____
Any concerns? _____

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