Office Use Only

VFC: [ ] State Stock
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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.*

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WT: _____kg _____lb

TEMP:_____

P: _____ R:_____

BP: _____ HT:_____

Vision: R: _____ L: _____

TECH: _____

Child's Name: _____ Birth Date: _____

Do you have any concerns about your child today? _____

Is your child on any medicine? Yes / No. Which ones/dose? _____

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? _____

Is your child's mom or dad on medication for (please circle) high cholesterol | hypertension | thyroid concerns | diabetes mellitus

Has the child's parent or grandparent had a stroke, heart attack, bypass surgery or stent or died suddenly before age 50? Yes / No.

Does anyone in the family have:

Asthma? Yes / No. please circle: father/mother/sibling.

Seasonal allergies? Yes / No. please circle: father/mother/sibling

Food allergies? Yes / No. please circle: father/mother/sibling. To what? _____

Has your child had any surgeries? Yes / No. If yes, describe: _____

Does your child have any chronic medical problems? _____

Nutrition

Dairy use? Circle one: Whole milk 2% 1% Skim Soy | How many total ounces of milk does your child consume 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? _____ 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? _____

Does your child eat a reasonable amount and variety of table foods? Yes / No.

Is your child on vitamins? Yes / No. Which ones? _____

Social

Any changes in your child's environment? (new home, pets, school, etc.) _____

Who lives in the household with you? _____

Which school does your child attend? _____

Grade Level: _____ Academic performance: _____

Behavior: _____ Teacher feedback: _____

Extracurricular activities: _____

How much vigorous physical exercise does your child get each day? _____

Any pets in your home? Yes / No. Which ones? _____

Does anyone in your home smoke? Yes / No. If yes, who? _____

Is Mom working? Yes / No. Full time / Part Time Occupation: _____

Is Dad working? Yes / No. Full time / Part Time Occupation: _____

Are there firearms in your home? Yes / No.

Name of Dentist:_____

Sleep and Elimination

Do you have any problems with: Sleep? Yes / No. Urinating? Yes / No. Stooling? Yes / No. # of stools / day_____

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.

FOR GIRLS ONLY:

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

This form completed by: _____. Relationship to Child: _____