

| Well Child Visit Questions | Ages 11-18 yrs old | | | | |
|--|---|--|---|----------------|------|
| Who is giving the information on this form? | Mother Father Legal guardian Stepparent | Uncle Aunt Brother Sister | Grandmother Grandfather Caseworker Foster parent | | |
| Who does the patient live with? | Mother Father Legal guardian Stepparent | Uncle Aunt Brother Sister | Grandmother Grandfather Caseworker Foster parent | | |
| What types of food does the patient eat? | Cereals Fruits Cow milk | Eggs Juices Fish | Sugary Drinks Meats Non-Food Items | | |
| Types of junk food consumed | Candy Chips | Fast Food Soda | Desserts Sugary Drinks | | |
| Is the patient physically active? | Yes | Unable to Exercise | No | | |
| How often does the patient get at least an hour of exercise? | Daily 4-5 times / week | More than once daily Less than weekly | 1-3 times / week | | |
| Does the patient have a pediatric Dentist? | Yes | No | | | |
| Brushes teeth regularly | Yes | No | | | |
| Flosses teeth regularly | Yes | No | | | |
| Last dental exam | Less than 6 months ago 6-12 months ago | | more than 1 year ago | | |
| Does the patient have problems with bowels or passing urine? | Urine Accidents Chronic Diarrhea Unable to make it to the toilet in time | | Poop Accidents Constipation | | |
| Do you have problems with any of the following: | Hitting Misbehaving with siblings (and / or) friends Mistreating siblings (and / or) friends Performing poorly in school | | Biting | Frequent Lying | |
| Disciplinary methods | Scolding Taking away privileges | | Praising Good Behavior | | |
| How many hours does the patient sleep? | Less than 8hrs | 8-10hrs | More than 10hrs | | |
| Does the patient snore at night? | Yes | No | | | |
| Does the patient have sleep problems? | Yes | No | | | |
| Does anyone smoke in the home? | Yes | No | | | |
| Does the home have working carbon monoxide detectors? | Yes | No | | | |
| Is there a gun in the home? | Yes | No | | | |
| What percent of the time is the car seat or seatbelt used? | 0% | 25% | 50% | 75% | 100% |
| What percent of the time is a helmet used? | 0% | 25% | 50% | 75% | 100% |

| | | | |
|--|---|-----------------|-------------------------------|
| Sun protection use | Regularly | Sometimes | Never |
| Insect repellent use | Regularly | Sometimes | Never |
| What sports protective devices are used? | Helmet Flotation device | | Eye Protection Mouth guard |
| What has your child been educated about the following: | Drug risks | Sexual privacy | Stranger risks |
| Current grade level | | | |
| Current school district | | | |
| Are there any signs or concerns about learning disabilities? | Yes | No | |
| School performance | Performing acceptably | Doing well | Struggling |
| Where is the child taken care of during the summer and after school? | Child's home | Daycare | Other |
| Childcare provider | Parent | Relative | Daycare Babysitter |
| Days per week at daycare | | | |
| Hours per day at daycare | | | |
| After school activities | Home with parent Home with sibling After school program (or sports) | | Home with adult Home alone |
| How well does the patient get along with siblings (if any)? | Well | Fair | Poor |
| Amount of time per day viewing a screen (computer, phone, television) | _____ hour(s) | _____ minute(s) | |
| Does the patient have a history of regular blood loss (e.g. heavy periods)? | Yes | No | N/A |
| Does the patient drink more than 24 ounces of milk per day? | Yes | No | |
| Does high cholesterol run in the family? | Yes | No | |
| Is the patient at risk for Tuberculosis (TB) (such as: travel to Latin America, Africa, Asia, or have known exposure to someone who has TB)? | Yes | No | |