Well Child Visit Questions	Ages 5-10 yrs old
Who is giving the information on this form?	Mother Uncle Grandmother Father Aunt Grandfather Legal guardian Brother Caseworker Stepparent Sister Foster parent
Who does the patient live with?	Mother Uncle Grandmother Father Aunt Grandfather Legal guardian Brother Caseworker Stepparent Sister Foster parent
What types of food does the patient eat?	Cereals Eggs Sugary Drinks Fruits Juices Meats Cow milk Fish Non-Food Items
Types of junk food consumed	Candy Fast Food Desserts Chips Soda 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 More than once daily 1-3 times / week 4-5 times / week Less than weekly
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 Poop Accidents Chronic Diarrhea Constipation Unable to make it to the toilet in time
Is there bedwetting	Yes No
Do you have problems with any of the following:	Hitting Biting Frequent Lying Misbehaving with siblings (and / or) friends Mistreating siblings (and / or) friends Performing poorly in school
Disciplinary methods	Scolding Praising Good Behavior Taking away privileges
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 Eye Protection Flotation device 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 adult Home with sibling Home alone After school program (or sports)
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 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