

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	