

# {Office Name} Previsit Questionnaire

## 5 Year Visit

For us to provide you and your child with the best possible health care, we would like to know how things are going. Please answer all of the questions. Thank you.

First Name

Last Name

Date of Birth

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

**Ready for School**

- Your child's fears about school
- After-school care
- Talking with your child's teacher
- Your child's friends
- Bullying
- Your child feeling sad

**Your Child and Family**

- Family time together
- Your child's chores
- Your child handling his feelings
- Your child being angry

**Staying Healthy**

- Your child's weight
- Eating fruits
- Eating vegetables
- Eating whole grains
- Getting enough calcium
- 1 hour of physical activity per day

**Healthy Teeth**

- Regular dentist visits
- Brushing teeth twice daily
- Flossing daily

**Safety**

- Street safety
- Booster seats
- Always wearing safety helmets
- Swimming safety
- Sunscreen
- Preventing sexual abuse
- Fire escape and fire drill plan
- Carbon monoxide alarms in your home
- Gun safety

### Questions About Your Child

Have any of your child's relatives developed new medical problems since your last visit?

- Yes
- No
- Unsure

If yes, please describe:

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**Lead - Does your child have a sibling or playmate who has or had lead poisoning?**

- Yes
- No
- Unsure

**Lead - Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months)renovated or remodeled?**

- Yes
- No
- Unsure

**Lead - Does your child live in or regularly visit a house or child care facility built before 1950?**

- Yes
- No
- Unsure

**Tuberculosis - Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?**

- Yes
- No
- Unsure

**Tuberculosis - Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?**

- Yes
- No
- Unsure

**Tuberculosis - Has a family member or contact had tuberculosis or a positive tuberculin skin test?**

- Yes
- No
- Unsure

**Tuberculosis - Is your child infected with HIV?**

- Yes
- No
- Unsure

**Anemia - Do you ever struggle to put food on the table?**

- Yes
- No
- Unsure

**Anemia - Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?**

- Yes
- No
- Unsure

**Does your child have any special health care needs?**

- Yes
- No

If yes, please describe:

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Have there been any major changes in your family lately?

- Move
- Job change
- Separation
- Divorce
- Death in the family
- Any other changes?

Please describe any other changes:

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Does your child live with anyone who uses tobacco or spend time in any place where people smoke?

- Yes
- No

## Your Growing and Developing Child

Do you have specific concerns about your child's development, learning, or behavior?

- Yes
- No

If yes, please describe:

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Check off each of the tasks that your child is able to do:

- Listens well and follows simple instructions
- Can tell a story with full sentences
- Counts to 10
- Names at least 4 colors
- Draws a person with 6 body parts
- Copies squares, triangles
- Writes some letters and numbers
- Balances on 1 foot
- Hops, skips, climbs
- Ties a knot