

# {Office Name} Previsit Questionnaire

## 8 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.**

- | School  | Your Growing Child  | Staying Healthy   | Healthy Teeth                                       | Safety   |
|---|---|---|---|--|
| <input type="checkbox"/> How your child is learning and doing in school | <input type="checkbox"/> How your child feels about herself   | <input type="checkbox"/> Your child's weight                        | <input type="checkbox"/> Regular dentist visits     | <input type="checkbox"/> Booster seats                                   |
| <input type="checkbox"/> Bullying                                       | <input type="checkbox"/> Following rules                      | <input type="checkbox"/> 1 hour of physical activity daily          | <input type="checkbox"/> Brushing teeth twice daily | <input type="checkbox"/> Helmets and sports safety                       |
| <input type="checkbox"/> After-school activities and care               | <input type="checkbox"/> Getting ready for puberty            | <input type="checkbox"/> Playing sports                             | <input type="checkbox"/> Flossing daily             | <input type="checkbox"/> Swimming safety                                 |
| <input type="checkbox"/> Special education needs                        | <input type="checkbox"/> Being angry                          | <input type="checkbox"/> TV time                                    |   | <input type="checkbox"/> Wearing sunscreen                               |
| <input type="checkbox"/> How your child acts                            | <input type="checkbox"/> Your child dealing with his problems | <input type="checkbox"/> Getting enough calcium                     |   | <input type="checkbox"/> Knowing your child's computer use               |
| <input type="checkbox"/> Talking with your child's school               | <input type="checkbox"/> Becoming more independent            | <input type="checkbox"/> Drinking enough water                      |   | <input type="checkbox"/> Knowing your child's friends and their families |
|   |   | <input type="checkbox"/> How much your child should eat at one time |   | <input type="checkbox"/> Gun safety                                      |
|   |   |   |   | <input type="checkbox"/> Smoke-free house and cars                       |
|   |   |   |   | <input type="checkbox"/> Preventing sexual abuse                         |

### 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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**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

**Dyslipidemia - Does your child have parents or grandparents who have had a stroke or heart problem before age 55?**

- Yes
- No
- Unsure

**Dyslipidemia - Does your child have a parent with elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?**

- Yes
- No
- Unsure

**Anemia - Does your child eat a strict vegetarian diet?**

- Yes
- No
- Unsure

**Anemia - If your child is a vegetarian, does your child take an iron supplement?**

- 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 following that are true for your child.**

- Eats healthy meals and snacks
- Has friends
- Is doing well in school
- Participates in an after-school activity
- Is vigorously active for 1 hour a day
- Does chores when asked
- Gets along with friends