

{Office Name} Previsit Questionnaire

9 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 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"/> Bicycle and sports safety and helmets |
| <input type="checkbox"/> Homework | <input type="checkbox"/> Dealing with your child's anger | <input type="checkbox"/> Your child's body image | <input type="checkbox"/> Brushing teeth twice daily | <input type="checkbox"/> Car safety |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Setting limits for your child | <input type="checkbox"/> Eating breakfast | <input type="checkbox"/> Flossing daily | <input type="checkbox"/> Swimming safety |
| | <input type="checkbox"/> Your child's friends | <input type="checkbox"/> Limiting soft drinks | | <input type="checkbox"/> Sunscreen |
| | <input type="checkbox"/> Readiness for middle school | <input type="checkbox"/> Eating together as a family | | <input type="checkbox"/> Knowing your child's friends and their families |
| | <input type="checkbox"/> Your child's sexuality | <input type="checkbox"/> Drinking enough water | | <input type="checkbox"/> Preventing cigarette, alcohol, and drug use |
| | <input type="checkbox"/> Puberty | <input type="checkbox"/> Limiting high-fat food | | <input type="checkbox"/> Gun safety |
| | | <input type="checkbox"/> 1 hour of physical activity daily | | |

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:

Vision - Do you have concerns about how your child sees?

- Yes
- No
- Unsure

Vision - Has your child ever failed a school vision screening test?

- Yes
- No
- Unsure

Vision - Does your child tend to squint?

- Yes
- No
- Unsure

Hearing - Do you have concerns about how your child speaks?

- Yes
- No
- Unsure

Hearing - Do you have concerns about how your child hears?

- Yes
- No
- Unsure

Hearing - Does your child have trouble hearing with a noisy background or over the telephone?

- Yes
- No
- Unsure

Hearing - Does your child have trouble following the conversation when 2 or more people are talking at the same time?

- 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 - 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:

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:

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:

11/2/2016

Check off each of the following that are true for your child.

- Eats healthy meals and snacks
- Has friends
- Is doing well in school
- Feels good about himself
- Participates in an after-school activity
- Is vigorously active for 1 hour a day
- Gets along with family
- Getting chances to make own decisions
- Does an activity really well - please describe

Please describe activity
