code: PD014

{Office Name} Previsit Questionnaire

10 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

- ☐ How your child is doing in school
- ☐ Homework
- ☐ Bullying

Your Growing Child

- ☐ How your child feels about herself
- ☐ Dealing with your child's anger
- ☐ Setting limits for your child
- ☐ Your child's friends
- ☐ Readiness for middle school
- ☐ Your child's sexuality
- ☐ Puberty

Staying Healthy

- ☐ Your child's weight
- ☐ Your child's body image
- ☐ Eating breakfast
- ☐ Limiting soft drinks
- ☐ Eating together as a family
- ☐ Drinking enough water
- ☐ Limiting high-fat food
- ☐ 1 hour of physical activity daily

Healthy Teeth

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

Safety

- ☐ Bicycle and sports safety and helmets
- ☐ Car safety
- ☐ Swimming safety
- ☐ Sunscreen
- ☐ Knowing your child's friends and their families
- ☐ Preventing cigarette, alcohol, and drug use
- ☐ 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:

_____

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 storke 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 you 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:

_____

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
- [ ] Gets along with family
- [ ] Participates in an after-school activity
- [ ] Vigorously exercises for 1 hour a day
- [ ] Does chores when asked
- [ ] Getting chances to make own decisions
- [ ] Does an activity really well - please describe

Please describe activity

_____