



Patient Name:

Date of Birth:

Well Child Check: 9-11 year visit questionnaire

Interval History:

Has your child had any major illnesses or doctor visits since last seen here? No Yes

Vision/Hearing and Development:

Has your child ever failed a school vision screening test? No Yes

Do you have concerns about how your child sees, hears, or speaks? No Yes

Have you talked to your child about puberty? Yes No

Are you concerned about your child's interaction with peers at school? No Yes

Does your child have friends at school? Yes No

Does your child have good physical coordination overall? Yes No

Does your child read for pleasure? Yes No

Does your child help with chores around the house? Yes No

Do you spend quality time together as a family? Yes No

School/Activities:

What grade level is your child in school? _____ Where? _____

Other activities (music/arts/sports/other)? _____

Is your child doing grade-level work at school? Yes No

What are your child's interests and goals? _____

Physical Activity:

Does your child exercise or play sports most days of the week? Yes No

Does your child have any chest pain or shortness of breath with exercise? No Yes

Has your child had a major sports related injury or concussion? No Yes

Nutrition/Elimination:

What type of milk does your child drink? _____ How much per day? _____ cups

How much yogurt per day? _____ How much cheese per day? _____

What dietary restrictions does your child have, if any? _____

How much juice or other sweet beverages does your child drink in a day? _____ oz

Is your child eating at least 5 servings of fruits and vegetables per day? Yes No

Does your child eat junk and/or fast food more than twice per week? No Yes

Does your child eat iron rich foods (meat, iron-fortified cereals, or beans)? Yes No

If your child is vegetarian, does he/she take an iron supplement? Yes No N/A

Are there any problems with pooping or peeing? No Yes

Dental Health:

Does your child brush his/her teeth daily? Yes No

Does your child see a dentist every 6 months? Yes No

Sleep:

How many hours does your child sleep at night? _____ hours

Does your child snore on a regular basis? No Yes

Staying Healthy and Safe:

Does he/she get more than 2 hours daily of screen time (NOT school related)?	No	Yes	
Is there a television or computer in your child's bedroom?	No	Yes	
Do you monitor your child's television and internet use?	Yes	No	
Does your home have a working smoke detector?	Yes	No	
Does your child know how to use 911 in an emergency?	Yes	No	
Do you always use a seat belt in the back seat (or use a booster if under 4' 9")?	Yes	No	
Is your child always supervised when near water and also able to swim?	Yes	No	
Does he/she use sun protection measures when outdoors?	Yes	No	
Is there a gun at home?	No	Yes	
If yes: Is the gun locked?	Yes	No	
Is the ammunition stored separately?	Yes	No	
If your child spends time with anyone who owns a gun/knife/other weapon, is the weapon safely stored and inaccessible to your child?	Yes	No	N/A
Have you discussed stranger awareness and personal safety with your child?	Yes	No	
Does your child wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	N/A
Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	
Has your child seriously injured another person or been seriously injured in the past year?	No	Yes	
Has your child ever bullied or been bullied (including cyber-bullied)?	No	Yes	
Does your child often seem sad or depressed?	No	Yes	
Are you concerned about your child's relationship with parents/siblings?	No	Yes	
Do you have concerns about how to set appropriate limits for your child?	No	Yes	
Does your child spend time with anyone who smokes or vapes?	No	Yes	
Has your child ever smoked cigarettes, chewed tobacco, or vaped?	No	Yes	
Are you concerned that your child is drinking alcohol, smoking, or abusing drugs (over-the-counter, prescription, sniffing glue)?	No	Yes	
Does your child have friends or family members who have a problem with drugs or alcohol?	No	Yes	

Please list your child's medications or supplements:

Please list any new major family medical issues: _____

Who lives in the home with your child? _____

What international travel has your child had since their last well check? (where and how long)

What plans are there for international travel with your child in the next 12 months? (where and how long)

What concerns would you like to discuss today?