7-8 Year Pre-Visit Questionnaire

***Instructions*:** Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.

General Health		
1. Do you have any concerns about your child's health?	NO	YES
Feeding/Nutrition		
2. Child has fruits or vegetables at every meal?	YES	NO
3. Giving your child mostly whole grains?	YES	NO
4. Is your child drinking milk?	YES	NO
a. What type of milk?		
b. How much milk per day?		
5. Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods daily?	NO	YES
6. Child drinks soda, juice, or other sweetened beverages?	NO	YES
7. Are you giving any vitamins or supplements?	YES	NO
Lipids		
8. Parents/grandparents with stroke/heart attack before 55?	NO	YES
9. Parent with high cholesterol or on cholesterol medication?	NO	YES
Oral Health		
10. Are cavities a problem for you or anyone in your family?	NO	YES
11. Brushing teeth twice a day and flossing once a day?	YES	NO
12. Sees dentist at least twice per year?	YES	NO
13. Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
School		
14. Problems with progress in school or ability to learn?	NO	YES
15. Problems with sitting still or concentrating in school?	NO	YES
16. Problems with getting along with teachers?	NO	YES
17. Problems with happiness, self esteem, self-confidence?	NO	YES
18. Problems with irritability, temper, outbursts, excessive anger?	NO	YES
19. Problems with peer relationships (lack of friends, bullying)?	NO	YES
Activity/Exercise/Screen time		
20. Does your child have more than 2 hours of screen time per day (TV, computer, video games)?	NO	YES
21. Is there a TV or video game system in child's bedroom?	NO	YES
22. Plays actively at least one hour per day?	YES	NO
23. Do you encourage activities such as walking, bicycling, swimming, or dancing?	YES	NO
24. Do you do educational activities as a family, such as go to museums, zoos, or libraries?	YES	NO
25. Do you eat meals together as a family?	YES	NO
26. Do you spend time alone with each of your children?	YES	NO

27. Do you spend time alone with your partner?	YES	NO

Social Stressors

28. Are you able to take a little time for yourself?	YES	NO
29. Is your partner hurting you or your children?	NO	YES
30. Any major changes or stresses in your family recently?	NO	YES
31. Do you ever fear your family will go hungry?	NO	YES

Safety

32. Rules about internet safety? Parental controls are set?	YES	NO
33. Have rules about answering the door and phone at home?	YES	NO
34. Wears a helmet when biking, skating, skiing or snowboarding?	YES	NO
35. Is child exposed to anyone who smokes?	NO	YES
36. Is there a gun in the home? a. Is it locked or in a safe?	NO	YES
37. Applying sunscreen when outside for a long time?	YES	NO
38. House has working smoke detectors and carbon monoxide detectors?	YES	NO
39. Using seatbelt or booster seat if *under* 4 feet 9 inches tall?	YES	NO
40. Do you have a home fire escape plan?	YES	NO

Tuberculosis

41. Has a family member or contact had tuberculosis disease?	NO	YES
42. Has a family member had a positive TB skin test (PPD)?	NO	YES
43. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
44. Has your child traveled to a high-risk country for more than a week?	NO	YES

Review of Systems

*Any **Concerns** about...*		
45. Eating habits, weight loss, or lack of energy?	NO	YES
46. Sleep problems, including excessive snoring?	NO	YES
47. Eye redness, excessive tearing, or discharge?	NO	YES
48. Recurrent ear, sinus or throat infections, nosebleeds?	NO	YES
49. Chest pain, shortness of breath or irregular heartbeat?	NO	YES
50. Frequent colds, cough, wheezing, recurrent lung infections?	NO	YES
51. Abdominal pain, vomiting, diarrhea, constipation?	NO	YES
52. Kidney or bladder problems, infections, blood in the urine?	NO	YES
53. Birthmarks, skin rashes, itching, nail or hair problems?	NO	YES
54. Joint pain, stiffness, swelling, muscle pain or weakness?	NO	YES
55. Recurrent headaches, dizziness, tics, weakness, seizures?	NO	YES
56. Mood changes, sadness, nervous problems?	NO	YES
57. Excessive thirst or hunger, increased urination?	NO	YES
58. Paleness, anemia, easy bruising, swollen glands?	NO	YES
59. Onset of puberty?	NO	YES