

Child's Name _____

Child's Birth Date _____

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Review of Nutrition

	Yes	No
Does she/he eat well-balanced diet, including fruits, vegetables, milk, and vitamins?	()	()
Does your child see a dentist twice a year?	()	()
Does your child brush her/his teeth 2 times daily?	()	()
Does your child floss her/his teeth once daily?	()	()

Elimination

	Yes	No
Is your child stooling comfortably?	()	()
Can your child always sleep through the night without wetting the bed?	()	()

Sleep

	Yes	No
Is your child sleeping well, without snoring often?	()	()
Is your child well rested during the day?	()	()

Puberty (girls only)

	Yes	No
Has your daughter begun to have periods? If so, when? _____	()	()
If so, are they regular and causing minimal pain?	()	()

Social Screening

	Yes	No
Are things going well overall for your family?	()	()
Is your home smoke-free? (choose "No" even if smoking is outside)	()	()
Does your child always sit in the back seat with seat belt on?	()	()
Does your child read regularly?	()	()
Does your child get along well with other children?	()	()
Are you happy with your child's behavior overall?	()	()
Is school going well?	()	()
Does your child get regular exercise?	()	()
Is screen time (TV, video games, computer) limited to <2 hours per day?	()	()
Is your family free of heart attacks and strokes in people younger than 55?	()	()
Tuberculosis (TB) risk?		
1. Contact with person who has tuberculosis	()	()
2. Your child is immuno-suppressed (HIV, cancer, chronic steroids)	()	()
3. Birth or travel to endemic Tuberculosis areas (Africa, Asia, Latin America, Caribbean)	()	()
4. Regular contact with adults at high risk for TB (Homeless, Jailed, Illegal drug user, HIV positive person, migrant farm worker, nursing home resident)	()	()

Has your child had any significant illnesses since the last time we saw you? If yes, please describe:

Are there any new stresses on your family since the last time we saw you? If yes, please describe:

Current concerns not listed above: