



7-8 Year Questionnaire

History

Do you have any concerns about your child?

Yes No

Does your child have any special health care needs?

Yes No

Has your child seen another doctor, been to the hospital, emergency room or urgent care since your last visit?

Yes No

Has your child had any procedures or tests done since their last visit?

Yes No

Household

How many people (not including this child) are living in this child's home? _____

If this child is not living with both biological parents, what is living situation?

Social History

Have there been any major changes for your child or in your family lately?

Yes No

Does your child live with anyone who smokes or spend time in any places where people smoke?

Does anyone smoke in the car your child travels in?

Yes No

Anemia Risk Assessment

Has your child ever been diagnosed with iron deficiency anemia?

Yes No

Do you ever have trouble getting food on the table?

Yes No

Is your child on a strict vegetarian diet?

Yes No

Does your child's diet include iron-rich foods like meat, eggs, beans or iron-fortified cereals?

Yes No

Tuberculosis Risk Assessment

Has your child been exposed to someone with tuberculosis?

Yes No

Has a family member or contact had a positive tuberculin skin test?

Yes No

Was your child born in a country with a high risk of tuberculosis (countries other than of the US, Canada, Australia, New Zealand or Western Europe)?

Yes No

Has your child traveled (and had contact with resident populations) for more than 1 week to a country at high risk for tuberculosis?

Yes No

Is your child infected with HIV?

Yes No

Dyslipidemia Risk Assessment

Has this child's parents or grandparents had a stroke or heart problem before the age of 55?

Yes No

Does this child have a parent or sibling that has high cholesterol (total cholesterol of 240 or higher) or taking cholesterol medication? _____

Nutrition

How many servings of dairy products does your child have per day? For example, yogurt and cheese.

Less than 2 2-3 more than 3

How many servings of vegetables does your child have per day?

Less than 3 3-5 more than 5

How many servings of fruits does your child have per day?

Less than 2 2-4 more than 4

How many servings of whole grains does your child have per day?

Less than 6 6-11 more than 11

How many servings of protein does your child have per day? For example, meat, eggs, beans, tofu, etc.

Less than 2 2-3 more than 3

How many servings of junk food does your child have per day? For example, chips, candy, cookies, cakes, etc. _____

How often does your child have a fast food meal?

More than 1 meal per day

1 meal per day

4-6 meals per day

1-3 meals per day

6-11 meals per year

1-5 meals per year

How many ounces (oz) of milk does your child drink per day? _____

How many ounces (oz) of juice does your child drink per day? _____

How many ounces (oz) of soda or drink mixes like Kool-Aid does your child drink per day? _____

Does your child take vitamins or supplements?

Yes No
Is your child on a strict vegetarian diet?
Yes No
Does your child eat breakfast every day?
Yes No
Does your child watch TV while eating?
Yes No
Do you have concerns about your child's weight?
Yes No
How often do you eat together as a family? _____

Physical Activity

How many hours a day does your child spend being physically active? _____

Is your family physically active together?

Yes No

How many hours a day does your child spend watching TV or other electronic device screen?

For example, computer, tablet, game console? _____

Sleep

How many hours does your child sleep per day? _____

Does your child have problems with sleeping?

Yes No

Oral Health

How often are your child's teeth brushed? _____

How often does your child see the dentist? _____

Is your child drinking water that is fluoridated?

Yes No

Has your child had fluoride varnish applied to their teeth in the last 6 months?

Yes No

Does your child snack frequently?

Yes No

Does your child continually drink from a sippy cup throughout the day?

Yes No

Does your child wear a mouth guard while playing sports?

Yes No

Is your child eligible for Medicaid?

Yes No

Have you, the parent or primary caregiver, had any cavities in the last 12 months?

Yes No

Vision

Do you have concerns about the way your child sees?

Yes No

Does your child squint often?

Yes No

Has your child ever failed school vision screening test?

Yes No

Hearing

Do you have concerns about the way your child hears?

Yes No

Do you have concerns about the way your child speaks?

Yes No

Does your child have difficulty hearing over a noisy background or over phone?

Yes No

School

Which school is your child attending? _____

Does your child participate in special education services?

Yes No

How does your child feel about school? _____

Do you have concerns about your child's school performance?

Yes No

Do you have concerns about your child's behavior?

Yes No

Do you have concerns about your child's attention?

Yes No

Do you have concerns about how your child interacts with others?

Yes No

Do you have concerns about your child's ability to do homework?

Yes No

Does your child have a routine and a place to do homework?

Yes No

Do you or your child's teacher have any other concerns?

Yes No

Who provides your child's after school care? _____

Do you show interest in your child's school and activities?

Yes No

Do you have concerns your child is being bullied or teased?

Yes No

Behavior

Is your child overall a happy person?

Yes No

Do you encourage your child to make good decisions?

Yes No

Does your child do simple chores?

Yes No

Is your child having problems interacting with you, other caregivers or siblings?

Do you use discipline to teach your child good behaviors and not as a way to punish?

Yes No

Do you teach your child to use words instead of violent behaviors?

Yes No

Has your child been getting into fights on the playground or other places?

Yes No

Safety

Does your child know what to do in an emergency if you are not there?

Yes No

Do you have a list of emergency numbers that are easy to find?

Yes No

Are there working smoke detectors in the house?

Yes No

Are there working carbon monoxide detectors in the house?

Yes No

Do you have a fire escape plan?

Yes No

Do you feel safe in your home?

Yes No

Do you feel safe in your community?

Yes No

Do you know how or where to get help if you don't feel safe in your home?

Yes No

In places where this child spends time, are medications, chemicals and insecticides kept locked up?

Yes No

Is the phone number for Poison Control easily located?

Yes No

When your child rides in a car, do you use a car seat or booster seat? _____

Where in the car is the car seat or booster seat located? _____

Does your child know street safety like stopping at a curb, looking both ways and never crossing the street without an adult?

Yes No

Is there a swimming pool, pond, or lake near your home or where your child spends time?

Yes No

Does your child know how to swim?

Yes No

Does your child wear sunscreen or sun protective clothing when outside?

Yes No

Does your child wear a helmet while biking, riding a scooter, skating, skateboarding, skiing, snowboarding, or horseback riding?

Yes No

Are there any guns in your home or where your child spends time?

Do you know your child's friends and their families?

Yes No

Does your child know it is never ok for an adult to tell a child to keep secrets from their parents?

Yes No

Does your child know it is never ok for an older child or adult to ask to see their private parts?

Yes No

Are there safety filters installed on all the computers and computer devices that your child uses?

Yes No

Do you regularly check your child's internet history?

Yes No

Is the computer that your child uses in a place you can easily see?

Yes No

Do you talk to your child about alcohol and the importance of not using it?

Yes No

Do you talk to your child about cigarettes and other tobacco products and the importance of not using it?

Yes No

Do you talk to your child about street drugs and the importance of not using it?

Yes No

Are you comfortable answering your child's questions about their body?

Yes No

Do you answer your child's questions about sex?

Yes No

Do you discuss with your child the importance of waiting to have sex?

Yes No