Pediatric Health Maintenance: 6-10 Years

Parent Questionnaire

Virginia Mason

Patient Information	
First & Last Name:	
Preferred Name:	
Date of Birth:	

General Health		☐ I'd like to discuss
☐ Yes	☐ No	Do you have concerns about your child's vision or hearing?
☐ Yes	☐ No	Do your child's eyes ever appear to cross or drift apart?
☐ Yes	☐ No	Does your child wet the bed?
☐ Yes	☐ No	Do you have any concerns about your child's sleep habits?
☐ Yes	☐ No	Does your child snore most nights?

Diet, Sleep, & Elimination		☐ I'd like to discuss
What type of milk does your child drink? ☐ Whole ☐ 1-2% ☐ Skim ☐ Other		
How much milk does your child drink each day?		
☐ Yes	☐ No	Does your child eat a good variety of foods (meat, vegetables, grains, and fruit)?
☐ Yes	☐ No	Are you worried about your child's weight or eating habits?
☐ Yes	☐ No	Does your child watch TV or play on a computer more than 1 hour per day?
☐ Yes	☐ No	Is your child involved in any activities such as sports or youth group?
		If yes, please list:

School		☐ I'd like to discuss
What school does your child attend?		What grade?
☐ Yes	☐ No	Do you have any concerns about how your child is doing in school?
☐ Yes	☐ No	Does your child receive any special help in school (e.g., LAP, IEP, etc.)? If "yes", what services does your child receive? Please specify:

Safety		☐ I'd like to discuss
☐ Yes	☐ No	Does your child use a helmet while biking, skating, or scootering?
☐ Yes	☐ No	Does your child still use a booster seat in the car?
☐ Yes	☐ No	Have you talked to your child about what to do if he or she sees or finds a gun?
☐ Yes	☐ No	Does your child know how to swim?
☐ Yes	☐ No	Are you afraid of your partner or anyone close to you?
☐ Yes	☐ No	Do you feel overly stressed or unsupported?

Specific Concerns/ Questions for Visit

☐ By typing my name in the box below, I understand that I am providing a binding electronic signature to the Well Visit 6-10 Years form.

Completed by (name and relationship to patient)

Date (month/day/year)