Well child

Pre-visit questionnaire

11-12 years

General

1.	List any concerns you want to discuss today:		
2.	Does your child have more than 2 hours of screen time per day (smartphone, tablet, TV — not including time spent on schoolwork)?	No	Yes
3.	Do you limit your child's access to screens in their bedroom?	Yes	No
4.	Does your child play actively for at least one hour per day?	Yes	No
5.	Does your child sleep 9 to 11 hours per night?	Yes	No
6.	Does your child have issues with anxiety, sadness, or anger?	No	Yes

Nutrition

7.	Is your child eating 5 or more servings of fruits and vegetables daily?	Yes	No
8.	Does your child eat junk food more than 2-3 times a week? (Examples: candy, chips, cookies, sweet cereal, fast food.)	No	Yes
9.	Does your child drink juice, soda or other sweetened drinks more than 1-2 times per week?	No	Yes
10.	Are you worried about your child's weight?	No	Yes
11.	Do you give your child any vitamins or supplements (including protein powders)?	No	Yes
12.	Does your child have a parent who has had a stroke or heart attack before age 55?	No	Yes
13.	Does your child have a parent or sibling with high cholesterol or on cholesterol medication?	No	Yes

Oral health

14.	Does your child see a dentist at least 2 times a year?	Yes	No

School

15.	What grade is your child in?
16.	What school does your child attend?

17. Is your child having problems with learning or concentrating in school?	No	Yes	
18. Is your child having problems with happiness or peer relationships (lack of friends, bullying)?	No	Yes	
19. Does your child have an IEP, 504 or other learning plan?	No	Yes	Not sure

Social stressors

20. Are you having any family stress?	No	Yes	
21. Within the past 12 months have you worried that your food would run out before you got money to buy more?	Never	Sometimes	Often

Tuberculosis

22. Is your child at risk for infection with tuberculosis? (Includes children born in Africa, Asia, Latin America, or eastern Europe; children who have stayed with family in one of those places for more than a week, or if exposed to anyone with active TB.)	No	Yes	Not sure

Adolescence

If appropriate for your child:

23. Have they gotten their period?	No	Yes
24. Do you or your child have concerns about menstruation (getting periods)?	No	Yes

Safety checklist

Check all that apply.

	True	I have questions
25. We have rules about answering the door at home and Internet safety (with parental controls set).	☐	☐
26. My child wears a helmet when biking, skating, skiing or snowboarding.	☐	☐
27. We apply sunscreen if out in the sun for longer than 15-30 minutes.	☐	☐
28. No one smokes or vapes around my child.	☐	☐
29. Our gun is locked up, with the ammunition separate (or we don't have a gun).	☐	☐