PEDIATRIC HEALTH MAINTENANCE – 6-10 Years
Parent Questionnaire

General

Question				
Do you have any concerns or worries about your child or your child's development?	______	No	______	Yes

If yes, please specify: ______________________________

Question				
Do you have concerns about your child's vision or hearing?	______	No	______	Yes
Do your child's eyes ever appear to cross or drift apart?	______	No	______	Yes
Does your child wet the bed?	______	No	______	Yes
Do you have any concerns about your child's sleep habits?	______	No	______	Yes
Does your child snore most nights?	______	No	______	Yes

Diet and Elimination

What type of milk does your child drink? ______________________________

How much milk does your child drink each day? ______________________________

Question				
Are you concerned about your child's weight or eating habits?	______	No	______	Yes
Does your child eat a good variety of foods (meat/protein, vegetables, grains, fruit)?	______	Yes	______	No
Does your child watch TV or play on a computer more than 1 hour per day?	______	No	______	Yes
Is your child involved in any activities such as sports or youth group?	______	Yes	______	No

If "yes, please list: ______________________________

____

School

What school does your child attend? ______________________________ What grade? ______

Question				
Do you have any concerns about how your child is doing in school?	______	No	______	Yes
Does your child receive any special help in school (e.g., LAP, IEP, etc.)?	______	No	______	Yes
If "yes", what services does your child receive? Please specify:	______	No	______	Yes

____

____

Safety

Question				
Does your child use a helmet while biking, skating, or scootering?	______	No	______	Yes
Does your child use a booster seat in the car?	______	No	______	Yes
Does your child ever ride in the front seat of the car?	______	Yes	______	No
Have you talked to your child about what to do if he or she sees or finds a gun?	______	No	______	Yes
Does your child know how to swim?	______	No	______	Yes
Are you afraid of your partner or anyone close to you?	______	No	______	Yes
Do you feel overly stressed or unsupported?	______	No	______	Yes

______________________________ ______________________________

Completed by (name and relationship to patient) Date (month/day/year)

PATIENT NAME

____

VIRGINIA MASON FRANCISCAN HEALTH
Pediatric Health Maintenance – 6-10 Years
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