PEDIATRIC HEALTH MAINTENANCE – 11-12 Years
Parent Questionnaire

General

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

If yes, please specify: _____

Do you have concerns about your child's vision or hearing? _____ No _____ Yes

Does your child snore most nights? _____ No _____ Yes

Have you begun talking to your child about puberty, dating, and sex? _____ Yes _____ No

Diet and Elimination

What type of milk does your child drink? _____

How much milk does your child drink each day? _____

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? _____

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

_____ _____

Does your child use a helmet while biking, skating, or scootering? _____ No _____ Yes

Does your child always use a seat belt in the car? _____ No _____ Yes

Does your child ever ride in the front seat of the car? _____ Yes _____ No

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 – 11-12 Years

VMMC99110 (08-24)

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