



# ABC Pediatrics

## 10-12 year Pre-visit Questionnaire

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Academics: (Above average) (Average) (Below average)

Socialization: Interacts well with family? YES NO Interacts well with peers? YES NO

Bathes: Daily Every other day Appetite: Good Fair Poor

Diet: Balanced? \_\_\_ Eats fast food? \_\_\_ Skips Meals? \_\_\_

Type of water (bottled/well/city): \_\_\_\_\_ # of hours sleeping at ONE time \_\_\_\_\_

Do you have any concerns about your child's hearing or vision? \_\_\_\_\_

Is there any secondhand smoke exposure in your home or car? \_\_\_\_\_

### Social Maturity (check all that apply)

- Concerned with appearance
- Shows interest in opposite sex
- Friends are very important
- Interested in sports/clubs
- Trusted to be left alone for period of time
- Able to cook simple foods

<b>TB Screen</b>	Has a family member or contact been diagnosed with TB?	YES	NO
	Was your child born in a country at high risk for TB?	YES	NO
	Has your child traveled to a country at high risk for TB?	YES	NO

Are there any other questions or concerns you would like to discuss?

\_\_\_\_\_

\_\_\_\_\_

Wt \_\_\_\_\_ Ht \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ T \_\_\_\_\_ Vision \_\_\_\_\_ Hearing \_\_\_\_\_