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?_____

Current Dentist:_____ Current School:_____

Social Maturity (check all that apply)

☐ Concerned with appearance ☐ Friends are very important ☐ Trusted to be left alone for period of time ☐ Able to cook simple foods

☐ Shows interest in opposite sex ☐ Interested in sports/clubs

TB Screen	**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?

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Wt_____ Ht_____ BP_____ P_____ T_____ Vision _____Hearing_____