



ABC Pediatrics

7-9 year Pre-visit Questionnaire

Patient Name _____ Date _____

Bathes: (daily) (every other day)

Interacts well with family? _____ Interacts well with friends? _____

Diet

Balanced Diet? _____ Picky eater? _____ Cups of milk daily _____

Problems with constipation? _____ Bed wetting? _____

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

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

Attends school@ _____ Grades are: Above Average Average Below Average

Developmental Milestones (check all that apply):

• Counts Coins	• Defines common objects in terms of use	• Likes to be around other kids similar age	• Engages in rough play
• Obeys 3 command succession	• Prints numbers 1-10	• Shares and cooperates	• Throws and catches
• Copies all shapes	• Draws a person with 6 parts	• Ties shoe laces	• Uses scissors
• Likes to help			

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?

[Type here]

Wt _____ Ht _____ BP _____ P _____ T _____ Vision _____ Hearing _____