

7-9 year Pre-visit Questionnaire

Patient Name		Date		
	Bathes: (daily)	(every other day)		
Inter	racts well with family?	_ Interacts well with frien	ds?	
	<u>ī</u>	<u>Diet</u>		
Balance	ed Diet? Picky eate	er? Cups of milk	daily	
P	roblems with constipation	? Bed wetting?		
Type of water	(bottled/well/city):	# of hours sleeping a	nt ONE time	
Is there a	ny secondhand smoke exp	osure in your home or car	?	
rent School:		Current Dentist:		
		ones (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 scissiors 	
• Likes to help				
	Has a family member or cor	ntact been diagnosed with TB?	YES NO	
TB Screen		country at high risk for TB?	YES NO	
	Has your child traveled to	a country at high risk for TB?	YES NO	
Are the	ere any other questions or	concerns you would like t	o discuss?	
Wt Ht	BP P	T Vision	Hearing	