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

| | | | |
|---|---|---|---|
| **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?

______________________________________________________________________

______________________________________________________________________

Wt______ Ht_______ BP_______ P_______ T______ Vision______ ____Hearing________________