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? _____

Current School:_____ Current Dentist:_____

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 scissiors
• 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?

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Wt_____ Ht_____ BP_____ P_____ T_____ Vision_____ Hearing_____