Parent/Caretaker Questionnaire for Well Child Visit

Child's Name_____ Date Completed_____

(Please complete form before your scheduled appointment)

Family History Question	Circle Answer	Parent / Caretaker Comments	Staff Use
1. Do the child's parents, sisters or brothers have serious hearing problems?	Yes / No		
2. Do the child's parents, sisters or brothers have a mental illness?	Yes / No		
3. Do the child's parents, sisters or brothers have any developmental (learning or physical) problems?	Yes / No		
4. Do the child's parents, sisters or brothers have inherited problems or birth defects?	Yes / No		
5. Do the child's parents, sisters or brothers have/had heart disease, heart attack or chest pain?	Yes / No		
6. Do the child's parents, sisters or brothers have high blood cholesterol (200 mg/dl or above)	Yes / No		
7. Do the child's parents, sisters or brothers or anyone living at home have T.B. (Tuberculosis)?	Yes / No		
8. Do the child's parents, sisters or brothers have untreated dental diseases (cavities, missing teeth)?	Yes / No		
9. Does the child's mother have a history of alcohol, prescription drug, illegal drug or tobacco use?	Yes / No		
10. Are there any other family and child health problems?	Yes / No		

Vision And Hearing Assessment: Question	Circle Answer	Parent / Caretaker Comments	Staff Use
11. Do you have any concerns about the child's vision /sight?	Yes / No		
12. Does child show any symptoms of eye or vision problems such as squinting, head tipping, eye rubbing etc...?	Yes / No		
13. Do you have any concerns about the child's hearing?	Yes / No		
14. Do you have any concerns regarding hearing, speech, language and/or developmental delay?	Yes / No		
15. Is there a family history of childhood hearing loss?	Yes / No		
16. Did mother have any infections during pregnancy such as cytomegalovirus, rubella, syphilis or toxoplasmosis?	Yes / No		
17. Does the child have any facial abnormalities including the ears?	Yes / No		
18. Was the child's birth weight less than 3.3 pounds?	Yes / No		
19. Did the child have jaundice that required him/her to receive blood transfusions?	Yes / No		
20. Has child had any medications that has decreased their ability to hear?	Yes / No		
21. Did the child have bacterial meningitis or any other infection associated with hearing loss?	Yes / No		
22. Was there a low Apgar score at birth with scores of 0 - 4 at one minute or 0 - 6 at five minutes?	Yes / No		
23. Was the child on a breathing machine (ventilator) five days or longer?	Yes / No		
24. Does the child have a disease, syndrome or other physical characteristic that is known to include vision or hearing loss?	Yes / No		

Vision And Hearing Assessment: Question	Circle Answer	Parent / Caretaker Comments	Staff Use
25. Has the child had a head injury associated with loss of consciousness (passing out) or skull fracture?	Yes / No		
26. Has the child had recurrent or persistent ear infections with fluid for at least 3 months?	Yes / No		

Developmental Assessment Questions	Circle Answer	Parent / Caretaker Comments	Staff Use
27. Were newborn screening test results normal?	Yes / No		

Mental Health / Substance Abuse Assessment Question	Circle Answer	Parent / Caretaker Comments	Staff Use
Answer these questions only if child is 3 years of age or older	Yes / No		
53. Is your child talking to you often about ending his life, about life being hopeless or of wanting to do serious self-harm? Does he talk about death often? Has your child ever spoken of a plan to kill himself?	Yes / No		
54. Does your child intentionally do things to hurt himself? Does he engage in dangerous or "risky" behaviors that might lead to injury?	Yes / No		
55. Have you noticed any signs of child abuse or neglect?	Yes / No		
56. Does your child have "weird" thoughts or behaviors that concern you or tend to be different from what most other children his age believes? Does you child hear, see, taste, touch or smell things that are not really there?	Yes / No		
57. Is there any evidence of a mental disorder?	Yes / No		
58. Is there any evidence of substance abuse such as alcohol, tobacco or any drug?	Yes / No		

Lead Assessment Questions	Circle Answer	Parent / Caretaker Comments	Staff Use
70. Does your child live in or regularly visit a house with peeling or chipped paint built before 1978?	Yes / No		
71. Does your child live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling?	Yes / No		
72. Does your child have a brother or sister, or a playmate with confirmed lead poisoning?	Yes / No		
73. Does your child live with a person whose job or hobby involved exposure to lead?	Yes / No		
74. Does your child live near an active lead smelter, battery recycling plant or other industry likely to release lead?	Yes / No		

81. Does your child participate in WIC?	Yes / No		

Oral Health Assessment Questions	Circle Answer	Parent / Caretaker Comments	Staff Use
91. Do you have well water?	Yes / No		
92. If you do have well water, has it been tested?	Yes / No		
93. Has child (age 2 years and over) been seen by dentist?	Yes / No		
94. Are child's teeth and gums brushed at least once per day?	Yes / No		
95. Have sealants been applied? (Ages 5-17 years)	Yes / No		
96. Does child drink water containing fluoride or city water?	Yes / No		
97. Does child take bottle to bed?	Yes / No		