Parental Concerns for Well Visits Age 9-14 years

Lori McAuliffe MD PA

Child's Name: ____________________________ Date: _______________________

Child's Age: ____________________________ Date of birth: ________________

Diet/Growth:

1. My child eats healthy foods: Yes No
   a. I wish my child ate more _________________________
   b. I wish my child ate less __________________________
2. I feel that my child is: Too heavy Too light Just right
   a. My child feels that his/her weight is: Too heavy Too light Just right
3. I feel that my child is: Too tall Too short Just right
   a. My child feels that his/her height is : Too tall Too short Just right
4. My child has started puberty: Yes No Unsure
   a. My child is happy with the appearance of his/her skin: Yes No Unsure
5. My child takes a vitamin: Yes No
   a. Which vitamin: _________________________________ Gummy Chewable Pill
6. My child drinks milk: Yes No
   a. ______ ounces per day
   b. Whole 2% 1% Skim Almond Soy Other ___________________
7. My child has a family history of high cholesterol: Yes No
   a. Who has high cholesterol? Mom Dad Aunt/Uncle Grandparent
   b. This is being treated with: Dietary changes Exercise Medications Not treated
8. My child gets exercise: Yes No
   a. At least 30 minutes a day? Yes No
   b. What sport or activity? ____
   c. My child complains of dizziness, shortness of breath, fatigue or chest pain during exercise? Yes No
   d. Is there a family history of cardiac death at a young age? Yes No Who? ___________________

Elimination:

1. My child has urine accidents: Yes No
   a. This happens: Daytime Night-time
   b. This bothers: My child My spouse No one is bothered
2. My child has stool daily: Yes No Don't know
   a. My child's stool is: Soft Hard Don't know

Sleep:

1. My child sleeps through the night: Yes No
   a. My child gets how many hours of uninterrupted sleep: _________ hours
   b. My child snores: Yes No
   c. My child has nightmares/sleepwalking/insomnia/sleep disturbance: Yes No
   d. My child looks at screens in the hour before bedtime: Yes No

Behavior:

1. My child is well behaved/minds: Yes No
   a. My child has trouble minding at: School Home Both
   b. I am concerned about my child's behavior: Yes No
2. I am proud of my child: Yes No

Learning:

1. My child attends school: Yes No Where: ________________________ Grade: ___________
2. My child gets good grades: Yes No Typical marks/grades: A's B's C's D's F's Not graded
3. My child's learning is: Advanced On grade Level Behind
4. My child can see well and hear well and speak clearly: Yes No
5. I worry that my child has a learning problem: Yes No

Other worries I have: ____ **Parent Signature**: ___________________________