Bright Futures 2022 PARENT Questionnaire for Well Visits Age 4-8 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 ____________________ I wish my child ate less ______________________
   b. We eat at least one meal per day together as a family: ☐ Yes ☐ No
2. I feel that my child is: ☐ Too heavy ☐ Too light ☐ Just right I feel that my child is: ☐ Too tall ☐ Too short ☐ Just right
3. My child takes a vitamin: ☐ Yes ☐ No
   a. Which vitamin: ________________________________ ☐ Gummy ☐ Chewable
   b. What time of day: ____________________ I wonder whether my child needs to take a vitamin: ☐ Yes ☐ No
4. My child drinks milk:
   a. ☐ Whole ☐ 2% ☐ 1% ☐ Skim ☐ Almond ☐ Soy ☐Other __________________
   b. ______ ounces per day
5. 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 ☐Unknown
6. My child is active/gets exercise: ☐ Yes ☐ No
   a. At least 30 minutes a day? ☐ Yes ☐ No
   b. What sport or activity? ____

Elimination:

1. My child has urine accidents: ☐ Yes ☐ No
   a. This happens: ☐ Daytime ☐ Night-time This bothers: ☐Me ☐ My child ☐ My spouse ☐ No one is bothered
   b. There is a family history of childhood bed-wetting in: ☐Mom ☐Dad ☐None ☐Other, please specify: __________
2. My child has stool daily: ☐ Yes ☐ No ☐ Don't know
   a. My child's stool is: ☐ Soft ☐ Hard ☐ Don't know My child has pain with pooping: ☐ Yes ☐ No
   b. My child has poop accidents: ☐ Yes ☐ No My child is holding his/her stool: ☐ Yes ☐ No

Safety:

1. My child can swim: ☐ Yes ☐ No We have a pool: ☐ Yes ☐ No We have a pool fence: ☐ Yes ☐ No
2. There is a gun in my home: ☐Yes ☐No It is stored (check all that apply) ☐Locked ☐Unlocked ☐Loaded ☐Unloaded ☐n/a
3. In the car, my child uses a booster seat or wears a seat belt? ☐ Yes ☐ No
4. On anything with wheels, my child wears a helmet? ☐Yes ☐ No

Sleep:

1. My child sleeps through the night: ☐ Yes ☐ No
   a. My child gets how many hours of uninterrupted sleep: ______ hours My child goes to sleep easily: ☐ Yes ☐ No
   b. My child snores: ☐ Yes ☐ No
   c. My child has nightmares/sleepwalking/sleep disturbance: ☐ Yes ☐ No
   d. My child looks at screens (TV, phone, computer) 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 **Parent Signature**: __________________________

Reviewed by Doctor: ☐McAuliffe ☐Class ☐Spector ☐ Bordon ☐Smith ☐Starr Kidder 1/2022