

# **Bright Futures 2023 PARENT Questionnaire for Well Visits Age 4-8 years**

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Child's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Child's Age: \_\_\_\_\_

Date of birth: \_\_\_\_\_

## **Diet/Growth:**

- My child eats healthy foods:  Yes  No
  - I wish my child ate more \_\_\_\_\_ I wish my child ate less \_\_\_\_\_
  - We eat at least one meal per day together as a family:  Yes  No
- I feel that my child is:  Too heavy  Too light  Just right I feel that my child is:  Too tall  Too short  Just right
- My child takes a vitamin:  Yes  No
  - Which vitamin: \_\_\_\_\_  Gummy  Chewable
  - What time of day: \_\_\_\_\_ I wonder whether my child needs to take a vitamin:  Yes  No
- My child drinks milk:
  - Whole  2%  1%  Skim  Almond  Soy  Other \_\_\_\_\_
  - \_\_\_\_\_ ounces per day
- My child has a family history of high cholesterol:  Yes  No
  - Who has high cholesterol?  Mom  Dad  Aunt/Uncle  Grandparent
  - This is being treated with:  Dietary changes  Exercise  Medications  Not treated  Unknown
- My child is active/gets exercise:  Yes  No
  - At least 30 minutes a day?  Yes  No
  - What sport or activity? \_\_\_\_\_

## **Elimination:**

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

## **Safety:**

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

## **Sleep:**

- My child sleeps through the night:  Yes  No
  - My child gets how many hours of uninterrupted sleep: \_\_\_\_\_ hours My child goes to sleep easily:  Yes  No
  - My child snores:  Yes  No
  - My child has nightmares/sleepwalking/sleep disturbance:  Yes  No
  - My child looks at screens (TV, phone, computer) in the hour before bedtime:  Yes  No

## **Behavior:**

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

## **Learning:**

- My child attends school:  Yes  No Where: \_\_\_\_\_ Grade: \_\_\_\_\_
- My child gets good grades:  Yes  No Typical marks/grades:  A's  B's  C's  D's  F's  Not graded
- My child's learning is:  Advanced  On grade Level  Behind
- My child can see well and hear well and speak clearly:  Yes  No
- I worry that my child has a learning problem:  Yes  No **Parent Signature:** \_\_\_\_\_