Bright Futures 2023 PARENT Questionnaire 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. I think 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. I think my child feels that his/her height is : □ Too tall □ Too short □ Just right
4. My child has started puberty: □ Yes □ No □ Unsure
   a. I think 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:
   a. □ Whole □ 2% □ 1% □ Skim □ Almond □ Soy □ Other _____
   b. _____ ounces per day
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 □Unsure
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 heart attack/stroke/unexplained death before 50? □Yes □No Who? _____

Elimination:

1. My child has urine accidents: □ Yes □ No
   a. This happens: □ Daytime □ Night-time
   b. This bothers: □ Me □ 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 at night: _____ 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 worry my child □Has anxiety □Has depression □Is being bullied □Is a bully □None of these
2. I am proud of my child: □ Yes □ No

Learning:

1. My child attends school: □ Yes □ No Where: _____ Grade: _____
2. My child's 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: □McAuliffeMD □ClassMD □SpectorMD □BordonMD □SmithMD □KidderMD □CrocusMD □ShahDO 11/22