Patient Name:

Date of Birth:

Well Child Check: 7 year visit questionnaire

Interval History:

Has your child had any major illnesses or doctor visits since last seen here?	No	Yes

Vision/Hearing and Development:

Do you have concerns about how your child sees?	No	Yes
Do you have concerns about how your child hears or speaks?	No	Yes
Does your child have good hand-eye coordination?	Yes	No
Are you concerned about your child's interaction with peers at school?	No	Yes
Does your child play cooperatively with other children?	Yes	No
Does your child read for pleasure?	Yes	No
Does your child help with chores around the house?	Yes	No

School/Activities:

What grade level is your child in school? __________________ Where? _____________________________

Other activities (music/arts/sports/other)? ____

Is your child doing grade-level work at school?	Yes	No

What are your child's interests and goals? ____

Nutrition/Elimination/Physical Activity:

What type of milk does your child drink? ___________________________ How much per day? ______ cups

How much yogurt per day? __________________________ How much cheese per day? _________________

What dietary restrictions does your child have, if any? ____

How much juice and sweet beverages does your child drink in a day?	______ oz		
Is your child eating at least 4 servings per day of fruits and vegetables?	Yes	No	
Does your child eat junk food and/or fast food more than twice per week?	No	Yes	
Does your child eat iron rich foods (meat, iron-fortified cereals, or beans)?	Yes	No	
If your child is vegetarian, does he/she take an iron supplement?	Yes	No	N/A
Are there any problems with pooping or peeing?	No	Yes	
Does your child exercise or play sports most days of the week?	Yes	No	

Dental Health

Does your child see a dentist every 6 months?	Yes	No
Does your child brush (with your help) her/his teeth daily?	Yes	No

Sleep:

How many hours does your child sleep at night?	______ hours	
Does your child snore on a regular basis?	No	Yes

Staying Healthy and Safe:

Does your child get screen time more than 2 hours per day?	No	Yes
Is there a television or computer in your child's bedroom?	No	Yes

Stanford Children's Health | Lucile Packard Children's Hospital Stanford
Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER ● 725 Welch Road, Palo Alto, CA 94304

Patient Name

Date of Birth

Questionnaire ● Well Child Check 7 Years

Do you monitor your child's television and internet use?	Yes	No	
Does your home have a working smoke detector?	Yes	No	
Is your child in a booster seat in the back seat (or use a seat belt if over 4' 9")?	Yes	No	
Is your child always supervised when near water and also able to swim?	Yes	No	
Does your child use sun protection when outdoors?	Yes	No	
Is there a gun at home?	No	Yes	
If yes: Is the gun locked?	Yes	No	
Is the ammunition stored separately?	Yes	No	
If your child spends time with anyone who owns a gun/knife/other weapon, is the weapon safely stored and inaccessible to your child?	Yes	No	N/A
Have you discussed stranger awareness and personal safety with your child?	Yes	No	
Does your child wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	N/A
Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	
Has your child seriously injured or been seriously injured in the past year?	No	Yes	
Has your child ever bullied or been bullied (including cyber-bullied)?	No	Yes	
Does your child often seem sad or depressed?	No	Yes	
Are you concerned about your child's relationship with parents/siblings?	No	Yes	
Do you have concerns about how to set appropriate limits for your child?	No	Yes	
Does your child spend time with anyone who smokes or vapes?	No	Yes	

Please list your child's medications/supplements:

___

Please list any new major family medical issues:

___

Who lives in the home with your child?

___

What international travel has your child had since their last well check? (where and how long)

___

What plans are there for international travel with your child in the next 12 months? (where and how long)

___

What concerns would you like to discuss today?

___