Reedsburg AREA MEDICAL CENTER
Physicians Group

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Patient Questionnaire – 6-8 Year Well Child

Patient Name:_____ Date of Birth:___/___/___ Date:_____

History Provided By (please circle)	Mother Stepparent Grandmother Aunt Father Brother Grandfather Foster Parent Legal Guardian Sister Uncle Caseworker
Lives With (please circle)	Mother Stepparent Grandmother Aunt Father Brother Grandfather Foster Parent Legal Guardian Sister Uncle
Interval Problems (please circle)	Caregiver depression Lack of social support Recent illness Caregiver stress Marital discord Recent injury Chronic stress at home
Nutrition	
Types of intake (please circle)	Eggs Fruits Junk food Non-nutritional Cereals Fish Juices Meats Vegetables Cow's Milk
Junk Food (please circle)	Candy Desserts Fast Food Soda Sugary Drinks Chips
Dental	
Has dental home (please circle)	Yes No
Brushes teeth regularly (please circle)	Yes No
Flosses teeth regularly (please circle)	Yes No
Last dental exam (please circle)	Less than 6 months ago 6-12 months ago More than a year ago

Please see reverse side

Elimination	
Elimination Problems (please circle)	Diarrhea Urinary Symptoms Constipation
Toilet Training (please circle)	Incomplete Complete
Bed wetting (please circle)	Yes No
Behavior	
Behavioral Issues (please circle)	Biting Hitting Misbehaving with peers Misbehaving with siblings Lying frequently Performing poorly at school
Disciplinary Methods (please circle)	Consistency among caregivers Scolding Taking away privileges Ignoring tantrums Spanking Praising good behavior Time outs
Sleep	
Average sleep duration in hours: _____	
Child Snores (please circle)	Yes No
Sleep Problems (please circle)	Yes No

Safety/Environment		
Smoking in home (please circle)	Yes No	
Working smoke alarms (please circle)	Yes No	Don't know
Guns in home (please circle)	Yes No	
Working CO (carbon monoxide) alarms (please circle)	Yes No	Don't know

School	
Grade Level (please circle)	Kindergarten 1st 2nd 3rd 4th **School district: _____**
Signs of learning disabilities (please circle)	Yes No
School performance (please circle)	Doing well Performing acceptably Struggling

Screening			
Immunizations up-to-date (please circle)	Yes No	**Risk factors for tuberculosis** (please circle)	Yes No
Risk factors for hearing loss (please circle)	Yes No	**Risk factors for lead toxicity** (please circle)	Yes No
Risk factors for anemia (please circle)	Yes No	**Risk Factors for dyspilidemia** (please circle)	Yes No

Social	
Caregiver enjoys child (please circle)	Yes No
After school activities (please circle)	Home with parent Home with a sibling Home alone An after school program Home with an adult
Sibling interactions (please circle)	Good Fair Poor
Screen time per day	_____ Minutes Hours