

6-7 Year Old Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your child's...

- | | | |
|--|------------------------------|-----------------------------|
| 1. Bowel movements..... | ☐ Yes | ☐ No |
| 2. Congestion or wheezing? | ☐ Yes | ☐ No |
| 3. Skin color or rashes (circle one)? | ☐ Yes | ☐ No |
| 4. Overall development? | ☐ Yes | ☐ No |
| 5. Communication skills? | ☐ Yes | ☐ No |
| 6. Bed wetting, soiling, or urinary control? | ☐ Yes | ☐ No |
| 7. Weight loss or gain? | ☐ Yes | ☐ No |
| 8. Recurrent ear infections? | ☐ Yes | ☐ No |
| 9. Nose bleeds or bruising? | ☐ Yes | ☐ No |
| 10. Weakness with walking up stairs, running, or climbing? | ☐ Yes | ☐ No |
| 11. Behavior at school, home, or daycare? | ☐ Yes | ☐ No |
| 12. Food allergies? | ☐ Yes | ☐ No |
| 13. Seasonal allergies? | ☐ Yes | ☐ No |
| 14. Chest pain? | ☐ Yes | ☐ No |
| 15. Chronic abdominal pain? | ☐ Yes | ☐ No |
| 16. Joint pain, joint swelling or limp? | ☐ Yes | ☐ No |
| 17. Overall progress/happiness/performance at school? | ☐ Yes | ☐ No |
| 18. Poor diet and/or picky eating? | ☐ Yes | ☐ No |

Answer the following:

- | | | |
|--|------------------------------|-----------------------------|
| 19. Is your child exposed to tobacco smoke? | ☐ Yes | ☐ No |
| 20. Were there any problems with immunizations in the past? | ☐ Yes | ☐ No |
| 21. Has your child traveled out of the country or do you plan to take your child to a country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the next year? | ☐ Yes | ☐ No |
| 22. Does your child eat non-food substances such as paint chips? | ☐ Yes | ☐ No |
| 23. Is your water source from a well? | ☐ Yes | ☐ No |
| 24. Does your child have any speech delays? | ☐ Yes | ☐ No |
| 25. Have problems sitting in their seat and paying attention at school? | ☐ Yes | ☐ No |
| 26. Is your child on the computer or playing video games or watching TV more than 2 hours per day? | ☐ Yes | ☐ No |

Does your child...

- | | | |
|---|------------------------------|-----------------------------|
| 27. Interact positively with teachers and friends and babysitters and siblings? | ☐ Yes | ☐ No |
| 28. Know all of his/her colors? | ☐ Yes | ☐ No |
| 29. Ride a bike with or without training wheels? | ☐ Yes | ☐ No |
| 30. Run well and keep up with their friends? | ☐ Yes | ☐ No |

6-7 Year Old Questionnaire

Answer the following:

31. Do you have smoke alarms? _____ Carbon monoxide detectors? _____
32. Do you know CPR? ☐ Yes ☐ No
33. Are you giving your child a multivitamin with iron? ☐ Yes ☐ No
34. Is your child eating all food groups: fruits, meats, and vegetables? ☐ Yes ☐ No
35. Is your child brushing their teeth? ☐ Yes ☐ No
36. Is your child seeing the dentist every 6 months? ☐ Yes ☐ No
37. Does your child ride in a booster seat or car seat in the back seat? ☐ Yes ☐ No
38. Participate in a sport or other organized activity? ☐ Yes ☐ No
39. How many ounces of milk does your child drink in one day? _____ What kind? _____
40. How many ounces of juice does your child drink in one day? _____

Screening questions for Tuberculosis:

1. Do you have a family member with TB or any contact with someone who has TB? ☐ Yes ☐ No
2. Do any family members have a positive TB test? ☐ Yes ☐ No
3. Was your child or any family members born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? ☐ Yes ☐ No
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? ☐ Yes ☐ No
5. Has your child ever drank unpasteurized milk or eaten unpasteurized cheese? ☐ Yes ☐ No
6. Do you plan to travel to a high risk country (one NOT listed above) within the next year? ☐ Yes ☐ No

Lead Screening:

Does your child...

1. Live in or regularly visit a house that was built before 1950? (Daycare, Babysitter, or relative) ☐ Yes ☐ No
2. Live in or regularly visit a house built before 1978 with recent ongoing renovations or remodeling (within the last 6 months? ☐ Yes ☐ No
3. Have a sibling or playmate who now has or did have lead poisoning? ☐ Yes ☐ No
4. Is your child a refugee from another country? ☐ Yes ☐ No

Name and Ages of Brothers _____
Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? ☐ Yes ☐ No

YOUTH PEDIATRIC SYMPTOM CHECKLIST-17 (Y PSC-17)

Name: _____ Record #: _____

Date of Birth: _____ Today's Date: _____

Please mark under the heading that best fits you:			NEVER	SOMETIMES	OFTEN
◆	Fidgety, unable to sit still	◆	0	1	2
✱	Feel sad, unhappy	✱	0	1	2
◆	Daydream too much	◆	0	1	2
□	Refuse to share	□	0	1	2
□	Do not understand other people's feelings	□	0	1	2
✱	Feel hopeless	✱	0	1	2
◆	Have trouble concentrating	◆	0	1	2
□	Fight with other children	□	0	1	2
✱	Down on yourself	✱	0	1	2
□	Blame others for your troubles	□	0	1	2
✱	Seem to be having less fun	✱	0	1	2
□	Do not listen to rules	□	0	1	2
◆	Act as if driven by a motor	◆	0	1	2
□	Tease others	□	0	1	2
✱	Worry a lot	✱	0	1	2
□	Take things that do not belong to you	□	0	1	2
◆	Distract easily	◆	0	1	2

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Total ◆ _____ Total □ _____ Total * _____ Grand Total ◆+□+* _____