Boulevard Center Pediatrics, Inc.

"Where your children are the center of our attention."

Well Visit Questionnaire (25 Months of Age – 10 Years of Age)

Patient Name: **Date of Birth:**

Date of Visit: **Parent/Caregiver Name of Person Completing Form:**

General Information:

1. Do you currently have any medical problems/illness? □ YES □ NO
   If YES, please explain:

2. Do you have any allergies(including medication, animals, food, etc?) □ YES □ NO
   If YES, please explain:

3. Do you take any medication? □ YES □ NO
   If YES, please explain:

4. Do you take any vitamins: □ YES □ NO
   If YES, please explain:

5. Did you visit the Emergency Room this year? □ YES □ NO
   If YES, please explain:

6. Did you have any major injury/fracture/concussion or fainting during exercise in the past? □ YES □ NO
   If YES, please explain:

7. Did you stay in the hospital for more than 1 day in the past? □ YES □ NO
   If YES, please explain:

8. Have you had any surgery in the past? □ YES □ NO
   If YES, please explain:

9. What grade are you in at school?

10. Do you participate in any sports? □ YES □ NO

Diet

1. Do you eat Breakfast, Lunch and Dinner on a daily basis? □ YES □ NO
2. Do you drink Milk? □Regular □1% □2% □Soy □Other_____ □ YES □ NO
3. Do you eat Vegetables or Fruits on a daily basis? □ YES □ NO
4. Do you eat Fast Food more than once a week? □ YES □ NO
5. Do you drink juice more than 2 days per week? □ YES □ NO

Elimination

1. Do you have a bowel movement every day? □ YES □ NO
2. Is your bowel movement □Soft □Hard
3. Do you have any issues with urination in bed or undergarments? □ YES □ NO
   3a. If YES, How often per week? _____times

Please turn page over for additional questions.

Sleep
1. Do you have regular sleep for at least 8 hours a day? □ YES □ NO
2. Do you snore loud or stop breathing during sleep? □ YES □ NO
3. Do you watch media within 2 hours prior to sleep? □ YES □ NO

School Performance
1. Are you doing satisfactory/well in school? □ YES □ NO
2. Do you have any problems in school with any subjects? □ YES □ NO
3. Do you have any problems with your hearing? □ YES □ NO
4. Do you have any problems with your vision? □ YES □ NO

Lead Risk Screening (If YES for any question below, please ask for a lead test.)
1. Do you live in or regularly visit a house built before the 1950s? □ YES □ NO
2. Do you live in or regularly visit a house built before 1978 that has recently been renovated? □ YES □ NO
3. Do you have a sibling or playmate who has or did have lead poisoning? □ YES □ NO

Dental Information (We recommend seeing a Dentist on a regular basis.)
1. Do you brush your teeth at least 2 times every day? □ YES □ NO
2. Do you brush your teeth with fluoride toothpaste on a regular basis? □ YES □ NO
3. Do you drink water from a Well as your water source? □ YES □ NO
4. Have you seen the Dentist within the past 12 months? □ YES □ NO

Tuberculosis Screening (If YES for any question below, please ask for TB test.)
1. Have you been abroad for more than 1 month in the past 5 years (outside of the US & Canada?) □ YES □ NO
2. Do you have a close contact of a person known to have TB? □ YES □ NO
3. Do you have a close contact of a person suspected to have TB (HIV+, Drug User or Prison Inmate?) □ YES □ NO

Social History:
Do you live with □Both Parents □Mom Only □Dad Only □Grandparents □Other _____

Mom Birth Year_____ Dad Birth Year_____

Any Smokers in the home? □ YES □ NO
Any Pets in the home? □ YES □ NO
Do you attend Daycare? □ YES □ NO

Family History (Please Check "√" where applicable)

Relation	Alive (A) or Deceased (D)	Asthma	Allergies	Diabetes	High Cholesterol	High Blood Pressure	Thyroid	Migraine	Other
Mother	□A □D								
Father	□A □D								
Siblings	How many Brothers? How many Sisters?								
Paternal Grandfather	□A □D								
Paternal Grandmother	□A □D								
Maternal Grandfather	□A □D								
Maternal Grandmother	□A □D								

Parent/Guardian Signature:_____

Administered/Reviewed By_____ Date:_____