



Pre-Visit Questionnaire Seven Year Visit

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today? _____

Questions about your child.

Have any of your child's relatives developed new medical problems since your last visit?
 Yes No Unsure If yes, please explain: _____

	Do you have any concerns about how your child speaks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Hearing	Do you have any concerns about how your child hears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child have trouble hearing with a noisy background or over the telephone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child have trouble following the conversation when 2 or more people are talking at the same time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

* Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries <u>other</u> than the United States, Canada, Australia, New Zealand, or Western Europe)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Anemia	Does your child eat a strict vegetarian diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	If your child is a vegetarian, does your child take an iron supplement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Have there been any major changes in your family lately? No Yes
 Move Separation Divorce Death in the family Job change Other _____

* Does your child live with anyone who uses tobacco or spend time in any place where people smoke? Yes No

Does your child have any special health care needs? Yes No If yes, please explain: _____

* List your child's current medications and doses: Include any herbs, vitamins or supplements: _____

* What is the best way to contact you (please circle): home phone / cell phone / work phone: _____

* Would you like to share your email address? _____