Pre-Visit Questionnaire
6 month Visit

What would you like to talk about today?

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

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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: ______________________

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	Question			
Hearing	Do you have any concerns about how your child hears?	❑ Yes	❑ No	❑ Unsure
Vision	Do you have any concerns about how your child sees?	❑ Yes	❑ No	❑ Unsure
LEAD	Does your child have a sibling or playmate that has had lead poisoning?	❑ Yes	❑ No	❑ Unsure
LEAD	Does you child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled?	❑ Yes	❑ No	❑ Unsure
LEAD	Does your child live in or regularly visit a house or child care facility built before 1950?	❑ Yes	❑ No	❑ Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	❑ Yes	❑ No	❑ Unsure
Tuberculosis	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	❑ Yes	❑ No	❑ Unsure
Tuberculosis	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	❑ Yes	❑ No	❑ Unsure
Tuberculosis	Is your child infected with HIV?	❑ Yes	❑ No	❑ Unsure
Oral Health	Are cavities a problem for you or anyone else in your family?	❑ Yes	❑ No	❑ Unsure
Oral Health	Does your child sleep with a bottle?	❑ Yes	❑ No	❑ Unsure
Oral Health	Does your child continuously breastfeed through the night?	❑ Yes	❑ No	❑ Unsure

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Have there been any major changes in your family lately? ❑ No ❑ Yes

❑ *Move* ❑ *Separation* ❑ *Divorce* ❑ *Death in the family* ❑ *Job change* ❑ *Other* ____________________

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things ❑ Not at all ❑ Several Days ❑ More than half the days ❑ Nearly every day
2. Feeling down, depressed, or hopeless ❑ Not at all ❑ Several Days ❑ More than half the days ❑ Nearly every day

* 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: ____________________

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

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

* Would you like to share your email address? ____