Fox Valley
WOMEN & CHILDREN'S
HEALTH PARTNERS

committed to providing full circle quality care

Got Questions? Get Answers. www.fvwchp.com

PATIENT NAME: ______________________________

Questions for 18 year and older visit

DATE: ______ / ______ / ______

Please complete the following questions as they apply to you.

NUTRITION

Do you drink milk? ❑ **yes** ❑ **no**

If yes, what type?

❑ whole ❑ 1% ❑ 2% ❑ skim ❑ soy ❑ rice

If yes, how much milk do you drink per day?

❑ < 8 oz ❑ 8 to 16 oz ❑ 16 to 24 oz ❑ 24 to 32 oz ❑ > 32 oz

How much juice, Gatorade, sports drinks, and soda pop do you drink per day?

❑ 0 to 4 oz ❑ 4 to 8 oz ❑ 8 to 16 oz ❑ > 16 oz

How much water do you drink per day?

❑ < 8 oz ❑ 8 to 16 oz ❑ 16 to 24 oz ❑ > 24 oz

How many meals do you eat per day?

❑ 1 to 2 ❑ 2 to 3 ❑ 3 to 4 ❑ > 4

Have you eliminated any main food groups from your diet?

❑ meats ❑ vegetables ❑ fruits ❑ grains/breads

ELIMINATION

Are you having any problems with your bowel movements? ❑ **yes** ❑ **no**

If yes, please explain. ______________________________

____

Are you having any problems with your urination? ❑ **yes** ❑ **no**

If yes, please explain. ______________________________

____

SLEEP

How many hours do you sleep at night?

❑ < 8 ❑ 8 to 10 ❑ 10 to 12 ❑ > 12

Do you have any problems with your sleep?

❑ snoring ❑ restless sleep ❑ paused or startled breathing ❑ difficulty falling asleep ❑ night terrors
❑ poor sleep quality (being tired after sleeping) ❑ frequent nighttime awakenings ❑ nightmares ❑ teeth grinding
❑ other: ______________________________

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VISION

Do you have any concerns regarding your vision? ❑ yes ❑ no

If yes, what? ______________________________

____

HEARING

Do you have any concerns regarding your hearing? ❑ yes ❑ no

If yes, what? ______________________________

____

SOCIAL AND SCHOOL DEVELOPMENT

Do you get along with others at home?	❑ yes	❑ no	❑ n/a
Do you get along with others at school?	❑ yes	❑ no	❑ n/a
Are you adjusting well to school?	❑ yes	❑ no	❑ n/a
Are you doing well in school?	❑ yes	❑ no	❑ n/a
Are you maintaining good school attendance?	❑ yes	❑ no	❑ n/a
Have you had any disciplinary problems at school?	❑ yes	❑ no	❑ n/a
Have you had any problems with the law?	❑ yes	❑ no	❑ n/a

PERSONAL HABITS

How much TV do you watch per day?

❑ none ❑ < 30 minutes per day ❑ < 1 hour per day ❑ 1 to 2 hours per day ❑ > 2 hours per day

How much time do you spend playing video games per day?

❑ none ❑ < 30 minutes ❑ < 1 hour ❑ 1 to 2 hours ❑ > 2 hours

What activities do you enjoy outside of school?

❑ sports ❑ bicycling ❑ exercise ❑ art ❑ using a computer
❑ videogames ❑ watching TV ❑ watching movies ❑ reading ❑ spending time with friends
❑ other: ______________________________

SAFETY

Do you wear a seat belt when riding in a car?	❑ yes	❑ no	
Do you wear a helmet or other protective gear for biking, skating, or water sports?	❑ yes	❑ no	❑ n/a
Do you ride on an ATV?	❑ yes	❑ no	
Is there a gun in your house?	❑ yes	❑ no	
If yes, is it kept unloaded and locked with the ammunition locked separately from the gun?	❑ yes	❑ no	

Do you have a pool? ❑ yes ❑ no

If yes, what type?

❑ above ground without a fence ❑ in ground without a fence ❑ above ground with a fence around the pool
❑ above ground with a fence around the yard ❑ in ground with a fence around the pool ❑ in ground with a fence around the yard

J.A.N. 27.2010 Signature of Provider ______________________________ Date: ______ / ______ / ______

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PATIENT NAME: ______________________________ AGE:__________

PROVIDER: ______________________________ DATE: _____/_____/_____

Tuberculosis Screening

In order to determine whether or not a TB test is indicated for your child, we need you to answer the following questions. Because exposure risks can change, we will ask you to update this questionnaire at the 6, 12, 18, and 24 month well child visits and then annually until 21 years of age.

Respond to the following questions by checking the appropriate answer.

Question			
Has a member of your family or a person who has contact with your child ad tuberculosis disease?	❑ Yes	❑ No	❑ Unknown
Has a family member had a positive tuberculin skin (TB) test?	❑ Yes	❑ No	❑ Unknown
Was your child born in a country with a high rate of tuberculosis (places other than the United States, Canada, Australia, New Zealand, or Western European countries) like Mexico, South and Central America, Asia, India, and Eastern European countries?	❑ Yes	❑ No	❑ Unknown
Has your child traveled (had contact with resident populations) to a high risk country for more than 1 week?	❑ Yes	❑ No	❑ Unknown

M.A.R. 5.2010 Signature of Provider ______________________________ Date: ______ / ______ / ______

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PATIENT NAME: ____

PROVIDER: ______________________________________ DATE: _____/_____/_____

Cholesterol Screening

Increasing evidence suggests that atherosclerosis (hardening of the arteries) and coronary heart disease (CHD) involve processes that begin in childhood and adolescence. Depending on family history, children at risk for hyperlipidemia (high fats in the blood) should be screened with a blood test (measuring either a cholesterol or LDL-C level depending on the risk factor) beginning at age two. Please complete this questionnaire to determine if your child has any of these risk factors. Screening can prevent complications by early recognition and treatment.

Respond to the following questions by checking the appropriate answer.

Question			
Does your child have a parent or grandparent who was diagnosed with coronary atherosclerosis (based on coronary angiography), including those who have had balloon angioplasty or coronary artery bypass surgery ≤ **55 years of age**?	❑ Yes	❑ No	❑ Unknown
Does your child have a parent or grandparent who has had a documented myocardial infarction (heart attack), angina pectoris (heart related chest pain), peripheral vascular disease (narrowing of the blood vessels within the body), cerebrovascualar disease (narrowing of the blood vessels within the brain or having had a stroke), or sudden cardiac death ≤ **55 years of age**?	❑ Yes	❑ No	❑ Unknown
Does your child have a parent with a cholesterol level ≥ **240**?	❑ Yes	❑ No	❑ Unknown

M.A.R. 5.2010 Signature of Provider ______________________________ Date: ______ / ______ / ______