

Child Name:	
Offina Harrio.	

Bright Futures Previsit Questionnaire Older Child/Early Adolescent Visits—For Parents

For us to provide your child with the best possible health care, we would like to know how things are going. Thank you.

What would you like to talk about today?							
Do you have any concerns, questions, or problems that you would like to discuss today?							
What changes or	challenges have there been at home since last year?						
-							
Does your child h	ave any special health care needs? No Yes, describe:						
Does your child li	ve with anyone who uses tobacco or spend time in any place where people smoke? \square No \square Yes	, describe	:				
How many hours per day does your child watch TV, play video games, and use the computer (not for schoolwork)?							
	Questions About Your Child						
	Does your child complain that the blackboard has become difficult to see?	Yes	No	Unsure			
	Has your child ever failed a school vision screening test?	Yes	No	Unsure			
Vision	Does your child hold books close to read?	Yes	No	Unsure			
	Does your child have trouble recognizing faces at a distance?	Yes	No	Unsure			
	Does your child tend to squint?	Yes	No	Unsure			
	Does your child have a problem hearing over the telephone?	Yes	■No	Unsure			
	Does your child have trouble following the conversation when 2 or more people are talking at the same time?	Yes	■No	Unsure			
Hearing	Does your child have trouble hearing with a noisy background?	Yes	□No	Unsure			
	Does your child ask people to repeat themselves?	Yes	■No	Unsure			
	Does your child misunderstand what others are saying and respond inappropriately?	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			
	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			
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	Yes	□No	Unsure			
	Is your child infected with HIV?	Yes	No	Unsure			
	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	Yes	No	Unsure			
Dyslipidemia	Does your child have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking	Yes	□No	Unsure			
	cholesterol medication?						
Anemia	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	No	Yes	Unsure			
	Has your child ever been diagnosed with iron deficiency anemia?	Yes	No	Unsure			

		For F	emales Only	У			
	Does your child have excessi				Yes	□No	Unsure
Anemia	Does your child's period last				-	No	Unsure
		Your Growing	and Develo	ping Child			
Check off all	of the items that you feel are truing My child engages in behavior My child has at least one remarks My child has at least one frim My child helps others individed My child is able to bounce be My child has a sense of hop My child has become more My child is particularly good	or that supports a healthy life sponsible adult in his life wh end or a group of friends wit dually or by working with a g back from life's disappointme refulness and self-confidenc independent and made more	o cares about him th whom she is co roup in school, a f ents. e. e of his own decisi	and to whom he can go to mfortable. aith-based organization, or to the come olde	if he needs help. the community. r.	nerself sa	afe.
	PUS	The questions		e answered by PARENT/I		- 4 <i>N</i> .	
	Westerville Pedi Specialists, In	The questions atric c.	s below are to be	e answered by PARENT/I		- AN.	
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American Academy of Pediatrics



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Westerville Pediatric Specialists, Inc.

575 Westar Crossing, Suite 101 Westerville OH 43082 Tel: 614/508-2223

Fax: 614/508-2233

CHOLESTEROL LIPID PANEL SCREENING

The American Academy of Pediatrics recommends that all children receive dyslipidemia screening between ages 9 to 11 and then again for those between 17-21 years old. The procedure consists of a simple finger stick and is analyzed in office.

I,	give my consent for my child
Parent's Name (prin	give my consent for my child nted)
	to have the chalestonal limid manal concerns a monformed by
Child's Name (printed)	, to have the cholesterol lipid panel screening performed by
-	
Westerville Pediatric Specialists, Inc.	
I <u>ACCEPT</u> cholesterol lipid panel screeni	ng at this time for my child.
Date	Signature
I <u>DECLINE</u> cholesterol lipid panel screen	ning at this time for my child.
Date	Signature