

Review of systems for ages:

6-9 years

Name: _____ **Date of Birth** _____

Date _____ **Chart # (Office use)** _____

(Please check the statements that apply to your child.)

- There is smoking in our home.
- There is a concern about a balanced diet.
- Body changes are beginning to occur.
- There is a concern about safety inside or outside of the child's home.
- There is a family or marital problem.
- There is a concern about my child's progression in school.
- There are questions about disciplining our child.
- There is a problem with bed wetting.
- My child is unusually sad or moody on a regular basis.
- My child has had an eye exam. If yes with Dr. _____ on _____.
- My child has dental exams. If yes, with Dr. _____ last performed on _____.
- I have questions on immunizations.
- I wish to talk with the provider about a confidential matter, without my child present.
- There are concerns that this questionnaire does not address.