

# Healthy Habits Survey

(2-18 years of age)

We are interested in the health and well being of our patients.

Please take a moment to answer the following questions.

Name – Date – DOB \_\_\_\_\_

1. How many servings of fruits and vegetables does your child eat a day? Fruit \_\_\_\_\_  
 • For ages 2 - 9 yrs, one serving is mostly easily identified by the size of the palm of **your child's hand**. Veg \_\_\_\_\_  
 • For ages 10 - 18 yrs, one serving is most easily identified by the size of the palm of **your hand**.

2. How many ounces of each of the following does your child drink a day?  
 Skim Milk \_\_\_\_\_ 100% Juice \_\_\_\_\_ Other Sweetened Drinks \_\_\_\_\_  
 1% Milk \_\_\_\_\_ Fruit Drinks \_\_\_\_\_ (sweet tea, punch, sports drinks)  
 2% Milk \_\_\_\_\_ Soft Drinks \_\_\_\_\_ Water \_\_\_\_\_  
 Whole Milk \_\_\_\_\_

3. How many times a week does your child eat takeout or fast food? \_\_\_\_\_
4. How many times a week does your child eat breakfast? \_\_\_\_\_
5. How many times a week does your child eat dinner at the table together with the family? \_\_\_\_\_
6. How many hours per day does your child watch TV/movies or sit and play video/computer games? \_\_\_\_\_
7. Does your child have a TV in the room where he/she sleeps? \_\_\_\_\_
8. Does your child have a computer in the room where he/she sleeps? \_\_\_\_\_
9. How much time a day does your child spend in active play (faster breathing/heart rate or sweating)? \_\_\_\_\_
10. Based on your answers, is there one thing that you would like your child or your family to change?

**Please check one box.**

- |   |  |
|---|--|
| <input type="checkbox"/> Eat more fruits & vegetables   | <input type="checkbox"/> Spend less time watching TV/movies and playing video/computer games |
| <input type="checkbox"/> Take the TV out of the bedroom | <input type="checkbox"/> Eat less fast food/takeout  |
| <input type="checkbox"/> Play outside more often        | <input type="checkbox"/> Drink less soda, juice, or punch                                    |
| <input type="checkbox"/> Switch to skim or 1% milk      | <input type="checkbox"/> Drink more water  |

**Does your child need to be screened for a lipid (cholesterol, triglyceride) disorder?**

The American Academy of Pediatrics recommends Lipid Screening in children with:

	Y	N	Relationship
• Family history of high cholesterol or triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Family history of early heart disease (i.e. heart attacks in men ≤ 55 years of age or women ≤ 65 years of age)	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Unknown family history	<input type="checkbox"/>	<input type="checkbox"/>	

*\*Also lipid screening is recommended in children with diabetes, high blood pressure and who are overweight or obese.*

Provider Signature \_\_\_\_\_