Well Child Check: School Aged Child (6-12 years)

Please answer the following questions. It will help your doctor spend more time discussing those specific issues that concern you. Please fill out BOTH SIDES.

Please list all medications/supplements/vitamins your child is CURRENTLY taking: _____

_____

_____

Please list any allergies your child has: _____

_____

Do you have concerns about your child's hearing? No Yes
Do you have concerns about your child's vision? No Yes

SOCIAL HISTORY

Are parents: O Married O Separated O Divorced O Other _____
Does anyone who lives with your child smoke? No Yes

SCHOOL

Current grade _____ Name of school _____
Do you have concerns about your *child's school performance?* No Yes Unsure
Has your child's *teacher raised concerns* about your child's school performance? No Yes Unsure
Do you have concerns about your child's *interactions with peers* at school? No Yes Unsure
Please list any activities your child participates in after school or on weekends: _____

_____

_____

MENTAL HEALTH

Do you have concerns about your *child's mood* (anxiety, depression)? No Yes Unsure
Do you have concerns about your child's *relationship with parents or siblings*? No Yes Unsure
Do you have concerns about how to *discipline /set appropriate limits* for your child? No Yes Unsure
If so, please explain: _____

NUTRITION

How much milk does your child drink everyday? ____ oz whole lowfat nonfat
How much juice/soda/sports drink does your child drink everyday? ____ oz
Does your child have any *dietary restrictions* (vegetarian, allergies)? No Yes Unsure
If yes, please describe: _____
Does your child *eat breakfast* before going to school? Yes No Unsure
Does your *family eat dinner together* 4 or more times per week? Yes No Unsure
Are you concerned about the amount of *junk food/fast food* your child eats? No Yes Unsure

PHYSICAL ACTIVITY

Does your child watch less than 2 hours of *TV/computer/video games* daily? Yes No Unsure
Is there a *television/computer in your child's bedroom*? No Yes Unsure
National guidelines recommend at least one hour of moderately strenuous activity daily (sports, biking, walking, working in the garden, etc.). Does your child meet this goal? Yes No
If no, what changes can you make to help your child meet this goal? _____

_____

_____

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ORAL HEALTH

Does your child *visit the dentist* about every six months?	Yes	No	Unsure
Does your child get *fluoride* daily from water or a supplement?	Yes	No	Unsure

SLEEP

Does your child *snore* on a regular basis?	No	Yes	Unsure
How many *hours of sleep* does your child usually get on weeknights?	_____ hours		
Do you have concerns about your child's sleep?	No	Yes	Unsure

If so, please describe: _____

_____

SAFETY

Do you monitor your child's *television and internet use*?	Yes	No	Unsure
Does your child wear a *helmet* when skiing/biking/skating?	Yes	No	Unsure
Does your child sit in a booster or wear a *seatbelt* in the car?	Yes	No	Unsure
Does your child wear *sunscreen* (SPF 30 or higher) when outdoors?	Yes	No	Unsure
Does your child know how to *stay safe around water* (pool, rivers, etc)?	Yes	No	Unsure
Have you discussed *stranger awareness* with your child?	Yes	No	Unsure
Does your child know how to *use 911* in an emergency?	Yes	No	Unsure
Are there *guns in the home* or any home your child regularly visits?	No	Yes	Unsure
Do you have concerns that your child is being *abused*?	No	Yes	Unsure

RISK ASSESSMENT FOR TUBERCULOSIS EXPOSURE/INFECTION

Has a family member or contact had tuberculosis disease?	No	Yes
Has a family member had a positive tuberculin skin test?	No	Yes
Was your child born in a high-risk country? *(High risk countries are those **other** than the United States, Canada, Australia, New Zealand, or western European countries)*	No	Yes
Has your child traveled to a high risk country, or has your child had contact with people who live in a high-risk country, for more than one week? *(High risk countries are those **other** than the United States, Canada, Australia, New Zealand, or western European countries)*	No	Yes

RISK ASSESSMENT FOR ABNORMAL LIPID PROFILE (SUCH AS HIGH CHOLESTEROL)

Did any of your child's parents or grandparents have significant heart disease at or before 55 years of age (had a heart attack, stroke, angioplasty, angina, or bypass surgery)?	No	Yes	Unsure
Do either of the child's parents have a cholesterol level of 240 or higher?	No	Yes	Unsure

Cholesterol screening may also be considered in anyone who is overweight, doesn't get much exercise, or who has high blood pressure or diabetes.

Do you have any other concerns you would like to discuss today?	No	Yes

If so, what are your concerns? _____

_____

_____