

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



Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the following questions, it will help your clinicians spend more time discussing those specific issues that concern you, PLEASE FILL OUT All PAGES.

Please list all CURRENT medications, vitamins, inhalers or supplements your child is taking:

Please list your child's medication or food ALLERGY if any:

Has your child had any major medical problems since his/her last check-up?	YES	NO	UNSURE
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Does your child have any previous/current injuries that still bother him/her?	YES	NO	UNSURE
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Do you have any concerns about your child's breathing?	YES	NO	UNSURE
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Do you have any concerns about your child's vision?	YES	NO	UNSURE
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Are your parent(s):

Married    Single    Separated    Divorced    Other:

Who lives with your child? Please list(mother, father, grandfather, sister, aunt, etc...):

Does anyone who lives with your child smoke?	YES	NO	UNSURE
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## SCHOOL:

Current grade/name of school:

Do you have concerns about your child's school performance?	YES	NO	UNSURE
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Do you have concerns about your child's interactions w/ peers at school? Please list any activities your child participates in after school or on weekends:

<b>NUTRITION:</b>			
Does your child drink more than 6oz of juice/soda/sports drinks daily?	YES	NO	UNSURE
Is your child a vegetarian?	YES	NO	UNSURE
Is your child a vegan?	YES	NO	UNSURE
Does your child get at least 3 servings of milk or other calcium containing foods daily?	YES	NO	UNSURE
<b>PHYSICAL ACTIVITY:</b>			
Does your child typically watch MORE than 2 hours of TV/computer/tablets/video games, etc. daily?	YES	NO	UNSURE
Is there a television/computer in your child's bedroom?	YES	NO	UNSURE
Has your child fainted while exercising?	YES	NO	UNSURE
Does your child cough or have shortness of breath with exercise?	YES	NO	UNSURE
Has your child had a significant head injury in the past 2 years?	YES	NO	UNSURE
Has a family member died suddenly with exercise?	YES	NO	UNSURE
Does your child get at least one hour of moderate strenuous activity most days?	YES	NO	UNSURE
<b>ORAL HEALTH:</b>			
Does your child see a dentist at least once a year(every 6 months is best)?	YES	NO	UNSURE
Does your child brush teeth at least two times daily?	YES	NO	UNSURE
<b>SLEEP:</b>			
Does your child snore on a regular basis?	YES	NO	UNSURE
Does your child get at least 8 hours of sleep on a typical school night?	YES	NO	UNSURE
Do you have any other concerns about your child's sleep, such as bed wetting? If YES, please describe:			

<b>SAFETY:</b>			
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 wear a seatbelt?	YES	NO	UNSURE
Does your child sit in a booster in the car?	YES	NO	UNSURE
Does your child usually wear sunscreen/hat/other sun protection measure when outdoors?	YES	NO	UNSURE
Does your child know how to stay safe around water (pools, lake, 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?	YES	NO	UNSURE
Do you have concerns your child is being abused?	YES	NO	UNSURE
<b>MENTAL HEALTH:</b>			
Do you have concerns about your child's mood (anxiety/depression)?	YES	NO	UNSURE
Do you have concerns about your child's relationship with parent's or siblings?	YES	NO	UNSURE
Do you have concerns about how to discipline/set appropriate limits for your child?	YES	NO	UNSURE
<b>GIRLS ONLY:</b>			
Has your daughter had her first period?	YES	NO	UNSURE
If YES, do you or she have any questions about her periods?	YES	NO	UNSURE

**Risk Assessment for Tuberculosis Exposure/Infection:**

Has a family member or close contact had tuberculosis disease?	YES	NO	UNSURE
Since your child's last well check has a family or close contact had a positive tuberculosis test?	YES	NO	UNSURE
Was your child born in a high-risk country (Countries other than the United States, Canada, Australia, New Zealand or Western European Countries)?	YES	NO	UNSURE
Has your child traveled to or had close contact with people who live in a high-risk country for more than one week (Countries other than the United States, Canada, Australia, New Zealand or Western European Countries)?	YES	NO	UNSURE

**Risk Assessment for Abdominal Lipid Profile (such as high cholesterol)**

Did any of your child's parents or grandparents have a significant heart disease at or before 55 years of age (had a heart attack, stroke, angioplasty, angina or bypass surgery)?	YES	NO	UNSURE
Do either of the child's parents have a cholesterol level of 240 or higher?	YES	NO	UNSURE
Do you have any concerns about your child's development?	YES	NO	UNSURE

Do you have any other concerns about your child that you would like to discuss with the provider? If YES, please describe below: