CHILDREN FIRST
DUMFRIES PEDIATRICS

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

Your Child's Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT BOTH SIDES.

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

_____

Please list your child's medication or food allergies, if any: _____

Has your child had any major medical problems since his or her last checkup?	Yes	No	Unsure
Does your child have any injuries that still bothers him or her?	Yes	No	Unsure
Do you have concerns about your child's hearing?	Yes	No	Unsure
Do you have concerns about your child's vision?	Yes	No	Unsure

Are Parent(s): Married Unmarried 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

School

Current grade/ name of school: _____

Do you have concerns about your child's school performance?	Yes	No	Unsure
Do you have concerns about your child's interactions with peers at school?	Yes	No	Unsure

Please list any activities your child participates in after school or on weekends:

_____

Nutrition

Does your child drink more than 6 oz. of juice/ soda/ sports drinks daily?	Yes	No	Unsure
Is your child a vegetarian?	Yes	No	Unsure
Does your child get at least 3 servings of milk or other calcium-containing foods daily?	Yes	No	Unsure

Physical Activity

Does your child typically watch MORE than 2 hours of TV/Computer/Video games, etc. daily?	No	Yes	Unsure
Is there a television/computer in your child's bedroom?	No	Yes	Unsure
Has your child fainted while exercising?	No	Yes	Unsure
Does your child cough or have shortness of breath with exercise?	No	Yes	Unsure
Has your child had a significant head injury in past 2 years?	No	Yes	Unsure
Has a family member died suddenly with exercise?	No	Yes	Unsure
Does your child get at least one hour of moderately strenuous activity most days?	Yes	No	Unsure

Oral Health

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

Sleep

Does your child snore on a regular basis?	No	Yes	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 bedwetting?	No	Yes	Unsure

If so, please describe:

_____

CONTINUES ON OTHER SIDE

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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 wear a seatbelt or sit in a booster in the car?	Yes	No	Unsure
Does your child usually use sunscreen/hats/other sun protection measures 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

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

For Girls Only

Has your daughter had her first period?	No	Yes	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 contact had tuberculosis disease?	Yes	No	Unsure
Since your child's last well check has a family member or 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 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 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)?	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, or any other concerns you would like to discuss with your provider? If so, please describe?	Yes	No	

CONTINUES ON OTHER SIDE