



WELL CHILD CHECK UP: 6 – 11 Years

Patient's Name _____ D.O.B. _____ Age _____ Date _____

Interval History:

Has your child been ill since the last check-up? Yes No If yes, please describe: (Hospitalization, surgery, ongoing illness) _____

What medications, supplements, or vitamins is your child taking, if any? _____

Does your child have any allergies? Yes No What kind? _____

Has your child had a reaction to shots before? Yes No If yes, describe: _____

What concerns or questions do you have about your child, if any? _____

Nutrition:

How is your child's appetite? Good Average Poor Cups of juice per day? _____

How many times a day does your child brush his/her teeth? _____ Cans/cups of soda per day? _____

Milk: Whole milk 2% or 1% Skim Soy How many cups a day? _____

Number of meals per day? _____ Servings of meat per day? _____ Servings of vegetables per day? _____

School:

What grade is your child in? _____ What school does your child attend? _____

What kind of grades does your child make? (Circle) A, B, C, D, F

Has your child ever repeated a grade? Yes No If yes, which grade & why? _____

What concerns, if any, do you have about your child's learning abilities or school performance? _____

What does your child want to become when he/she grows up? _____

Safety / Home:

Does your child use a seat belt? Yes No Booster seat? Yes No

Do you have a working smoke detector? Yes No Is there a gun in your home? Yes No

Is your child exposed to smoke? Yes No

Does your child... *Check box if YES* Play sports Run Ride a bike Wear a helmet

Is your child (circle): happy sad playful shy? Is he/she able to get along with others? Yes No

Who lives in your household? _____

Any pets? If yes, what kind? _____

Has anyone physically abused or threatened you or your children? Yes No

TB Screening Questions: Has your child been around anyone ... who has HIV or uses IV drugs? Yes No

... who lives in a group or nursing home? Yes No ... who has traveled to another country? Yes No

... who has been homeless or incarcerated (in jail)? Yes No

Behavior:

What do you do when your child misbehaves? _____

Any behavior problems? Yes No If yes, describe: _____

What time does your child go to sleep? _____ Wake up? _____

How many hours of TV does your child watch per day? _____

Do you want to discuss (check if Yes): Eating problems Sleep problems Urine / bowel problems

Girls Only: Have you had a period yet? Yes No If yes, please answer questions below.

How old were you when you got your first period? _____ When was your last period? _____

→ Please indicate relationship of person completing form: _____

Signature: _____

Date: _____