6-10 Years – well child care Name:_____

Household

Who lives in the home (e.g. Father, mother, brother, etc.)? _____

Development

Doing well in school	Yes	No
Interacts well with others	Yes	No
Maintains Friendships	Yes	No
Acceptable behavior at home and in school	Yes	No
Engages in regular exercise	Yes	No
Television watching less than 2 hours/day	Yes	No

Nutrition

Eats three meals per day with snacks	Yes	No
Drinks 1-2% milk	Yes	No
Eats relatively well balanced diet	Yes	No
Well water or city water?	Well	City

Bowel Habits

Every day or every other day stool	Yes	No
Stooling is painless and non-bloody	Yes	No

Sleep Pattern

Having nightmares or sleepwalking	Yes	No

Safety

Wears a seat-belt and if appropriate uses a booster seat in automobile ?	Yes	No
Wears a helmet when cycling/boarding/skating?	Yes	No
Are there smoke detectors in your house	Yes	No
Is your child exposed to tobacco smoke?	Yes	No
Are there any improperly stored firearms in the home?	Yes	No
Is the hot water temperature set low enough to prevent accidental burns?	Yes	No
Are there working smoke detectors in the home?	Yes	No

Miscellaneous

Any questions or concerns about your child?	Yes	No

If yes, what are they?

Please circle any of the questions below to which your answer is "YES".

Lead Risk Assessment:

- Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- Ever lived outside the United States or recently arrived from a foreign country?
- Sibling, housemate/playmate being followed or treated for lead poisoning?
- If born before 1/1/2015, lives in a 2004 "at-risk" zip code?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items?
- Contact with an adult whose job or hobby involves exposure to lead?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead.
- Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Was your child born in, or lived more than a year in a country other than the U.S.?
- Has your child been exposed to anyone with either active or a history of Tuberculosis disease?
- Is your child living in a house hold with anyone who is HIV Positive?
- Is your child part of a migrant worker family?

Heart Disease/Cholesterol Risk Assessment:

- Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?
- Has the child's mother or father been diagnosed with high cholesterol? (240 mg/dL or higher)
- Is the child/adolescent overweight?
- Does the patient have a history of smoking?
- Does the patient have a history of Lack of physical activity?
- Does the patient have a history of High blood pressure?
- Does the patient have a history High cholesterol?
- Does the patient have a history Diabetes Mellitus?

Below this line is for Office Use:

Weight _____

Height _____

Head Circumference _____

Blood Pressure _____

Vision Test: Left 20/ ___ Right 20/___

Hearing Test: