School Aged – well child care Patient Name:_____D.O.B_____

Please fill in the blank or check the appropriate answer as it pertains to your child.

Household

Who lives in the home (Father, mother, brother, sister, 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 one hour of exercise daily_____	▢ Yes	▢No
Recreational screen time less than 2 hours per day _____	▢ Yes	▢No

Please list after school activities like sports and clubs. _____

_____

Nutrition

Does your child drink milk? If so what kind_____	▢Whole Milk	▢Soy Milk	▢Other _____
Do they drink approximately 16oz (480ml) per day ? _____	▢ Yes	▢No	
Avoiding excess added sugars (juice, candy, sweets) and animal fats?_	▢ Yes	▢No	
Consuming green vegetables?_____	▢ Yes	▢No	

Bowel habits

Every day or every other day bowel movement?_____	▢ Yes	▢No
Bowel movements are painless and non-bloody? _____	▢ Yes	▢No

Safety

Wears a seat-belt or if appropriate uses a cars seat or booster seat in the automobile?	▢ Yes	▢No
Wears a helmet with cycling/boarding/skating?_____	▢ 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

Please share any concerns that you have about your child here:

_____

_____

_____

_____

_____

_____

Please complete both sides of this form

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

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 child have a history of smoking?
- Does the child have a history of Lack of physical activity?
- Does the child have a history of High blood pressure?
- Does the child have a history High cholesterol?
- Does the child have a history Diabetes Mellitus?

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?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, or 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 stores or serves food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Your child was born in, traveled to or lived in a "tuberculosis high-risk" country?
- Your child has a family member or has had contact with anyone with either active tuberculosis or a history of tuberculosis disease?
- Your child has a family member with a positive tuberculin skin test?

Social Determinants of Health Assessment:

- Within the past 12 months, have you had worries that food would run out before your family got enough money to buy more?
- Within the past 12 months, were there times that food ran out and your family didn't have enough money to get more?
- Have you needed help reading instructions, pamphlets, or other written material from a doctor or pharmacy?
- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Below this line is for Office Use:

Weight _____

Height _____

Blood Pressure _____

Vision Test: Left 20/ ___ Right 20/___ Hearing Test: Passed Failed

Please complete both sides of this form