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

Your Child's Name: _____

Please answer the following questions. It will help your clinician spend more time discussing those specific issues that concern you. Please fill out BOTH SIDES.

Please list all medications, vitamins, inhalers or supplements that 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?	No	Yes
Does your child have any injuries that still bothers him or her?	No	Yes
Do you have concerns about your child's hearing?	No	Yes
Do you have concerns about your child's vision?	No	Yes

Are parents: ☐ Married ☐ Separated ☐ Divorced ☐ Other _____

Does anyone who lives with your child smoke?	No	Yes

SCHOOL

Current grade / name of school _____

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

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

_____

_____

NUTRITION

How much juice/soda/sports drink does your child drink everyday?	_____ oz		
Is your child a vegetarian?	No	Yes	
Does your child get at least 4 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
Does your child get *at least one hour* of moderately strenuous activity most days?	Yes	No	

ORAL HEALTH

Does your child *visit the dentist* about every six months?	Yes	No	Unsure
Does your child get *fluoride* daily from water or a supplement?	Yes	No	Unsure
Does your child brush teeth at least two times daily?	Yes	No	

SLEEP

Does your child *snore* on a regular basis?		No	Yes	Unsure
How many hours per night does your child usually sleep?	☐ 9+	☐ 7 - 9	☐ fewer than 7	
Do you have concerns about your child's sleep?		No	Yes	Unsure

If so, please describe: _____

_____

_____

Gabriel C. Millar, M.D. P. A.
16040 Park Valley Drive
Ste # 227
Round Rock, TX 78681
Tel: 512.255.7337
Fax: 512.828.0451

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

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	
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

If so, please explain: _____

FOR GIRLS ONLY

Has your daughter had her first period?	No	Yes
If yes, do you or she have any questions about her periods?	No	Yes

RISK ASSESSMENT FOR TUBERCULOSIS EXPOSURE/INFECTION

Has a family member or contact had tuberculosis disease?	No	Yes
Has a family member had a positive tuberculin skin test?	No	Yes
Was your child born in a high-risk country? *(High risk countries are those* ***other*** *than the United States, Canada, Australia, New Zealand, or western European countries)*	No	Yes

Has your child traveled to a high risk country, or has your child had contact with people who live in a high-risk country, for more than one week? *(High risk countries are those* ***other*** *than the United States, Canada, Australia, New Zealand, or western European countries)*	No	Yes

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)?	No	Yes	Unsure
Do either of the child's parents have a cholesterol level of 240 or higher? *Cholesterol screening may also be considered in anyone who is overweight, doesn't get much exercise, or who has high blood pressure or diabetes.*	No	Yes	Unsure

Do you have any other concerns you would like to discuss today?	No	Yes

If so, what are your concerns? _____

_____

_____

_____ _____

Print Name Relationship to Patient

_____ _____

Signature Date