TRI-COUNTY FAMILY MEDICINE ASSOCIATES

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Well Child Ages 6 to 12 Years Old

Child's Name: _____ Date of Birth:_____

Please answer the following questions. It will help your medical provider spend more time discussing those specific issues that concern you.

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

Are Parent(s): (Circle) **Married Unmarried Single Separated Divorced**
Other: _____

Who lives with your child? Please list below: (Example: mother, father, grandfather, sister, aunt, etc.)

_____

Do you have concerns about your child's hearing?	**Yes**	**No**
Do you have concerns about your child's vision?	**Yes**	**No**
Does anyone who lives with your child smoke?	**Yes**	**No**

School

Current grade: _____ Name of School: _____

Do you have concerns about your child's school performance (Example: grades, getting along with teachers)?	**Yes**	**No**
Do you have concerns about your child's interactions with peers at school (bullying or fighting)?	**Yes**	**No**

Nutrition

Does your child drink more than 12 oz. of soda/ sports drinks daily?	**Yes**	**No**
Is your child a vegetarian?	**Yes**	**No**
Does your child skip meals routinely?	**Yes**	**No**
Does your child struggle with Anorexia, Bulimia, Obesity, or being Underweight?	**Yes**	**No**
Does your child get at least 3 servings of milk or other calcium-containing foods daily?	**No**	**Yes**

How many servings of fruits and vegetables does your child eat each day?_____

Physical Activity

Does your child typically watch MORE than 2 hours of TV/Computer/Video games, etc. daily?	**Yes**	**No**
Has your child fainted while exercising?	**Yes**	**No**
Does your child cough or have shortness of breath with exercise?	**Yes**	**No**
Has your child had a significant head injury in past 2 years?	**Yes**	**No**
Does your child get at least 30 minutes of moderately strenuous activity most days?	**No**	**Yes**

Child's Name: _____

Oral Health

Does your child see a dentist at least once a year? (every 6 months is best)	**No**	**Yes**
Does your child brush teeth at least two times daily?	**No**	**Yes**

Sleep

Does your child snore on a regular basis?	**Yes**	**No**
Does your child get at least 8 hours of sleep on a typical school night?	**No**	**Yes**
Do you have any other concerns about your child's sleep, such as bedwetting	**Yes**	**No**

If so, please describe:

Safety

Does your child wear a helmet when skiing/skating/biking/on ATV, dirt bike, motorcycle?	**No**	**Yes**	**Sometimes**
Does your child wear always wear a seatbelt when in the car?	**No**	**Yes**	**Sometimes**
Does your child usually use sunscreen/hats/other sun protection when outdoors	**No**	**Yes**	**Sometimes**
Does your child know how to stay safe around water (pool, rivers, etc)?	**No**	**Yes**	
Have you discussed stranger awareness with your child?	**No**	**Yes**	
Does your child know how to use 911 in an emergency?	**No**	**Yes**	
Are there guns in the home or any home your child regularly visits?	**Yes**	**No**	
Do you have concerns that your child is being abused?	**Yes**	**No**	
Do you have concerns that your child is drinking alcohol?	**Yes**	**No**	
Do you have concerns that your child is using drugs?	**Yes**	**No**	

Mental Health

Do you have concerns about your child's mood (anxiety, depression)?	**Yes**	**No**
Do you have concerns about your child's relationship with parents or siblings?	**Yes**	**No**
Has your child ever threatened to hurt themselves?	**Yes**	**No**

For Girls Only

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