Well Child Questionnaire for Children 6-10 Years Old

Patient name: _____ Birthdate: _____

Person completing form: _____ Today's date: _____

Please list any changes in the patient's home since the last visit. _____

_____

Please list any medical care received outside of our office since the last visit. _____

_____

Please list all of the patient's current medications. _____

_____

Please list any known food or medication allergies. _____

Please circle or fill in where indicated.

1) Does the patient get at least 3 servings of calcium a day? (ex. milk, yogurt, cheese) Yes No

Please note that all dairy should be low fat or non fat.

2) Please list any multivitamins or supplements that the patient takes. _____

3) Do any close family members have or take medicine for high cholesterol, high triglycerides, or blood sugar problems? Yes No

4) Have any close family members had a stroke, heart attack, bypass surgery, or peripheral vascular disease before the age of 55? Yes No

5) Please list any concerns regarding the patient's sleep. _____

_____

6) Is the patient having urine or stool accidents regularly? Yes No

If yes, please describe. _____

7) What grade/school does the patient attend? _____

8) Please list any concerns regarding the patient's speech. _____

9) Is the patient receiving any assistance for learning difficulties? Yes No

10) Please list any ongoing concerns regarding the patient's academic or social progress? _____

_____

11) Please list other activities the child is involved in other than school. _____

_____

12) The patient should see a dentist 2x a year or as directed by their dentist. The patient should wear protective gear for all sports/activities and must remain in a car seat or booster seat until at least 8 years of age.

Tuberculosis Risk Questionnaire

Was the patient born in or has the patient traveled to any of the following areas: Africa, Asia, Latin America, Eastern Europe or Russia? Yes No If yes, where: _____

Was the patient exposed to a household member who was born in or traveled to any of the above listed areas?

Yes No If yes, to whom was the patient exposed: _____

Was the patient exposed to anyone with known tuberculosis or anyone who had a positive skin or blood test for tuberculosis?

Yes No If yes, to whom was the patient exposed: _____

Does the patient spend time with someone who has been in a shelter, prison/jail or someone who uses illegal drugs or has HIV?

Yes No If yes, please explain:_____ _____