OBERLIN ROAD PEDIATRICS

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

Your Child's Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT BOTH SIDES.

Please list all the medications, vitamins, inhalers or supplements 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(s): Married Unmarried Single Separated Divorced Other: _____

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

_____

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
Do you have concerns about your child's interactions with peers at school?	No	Yes

What interests/activities does your child have? Where does your child excel?

_____

Nutrition

Does your child drink more than 6 oz. of juice/ soda/ sports drinks daily?	No	Yes
Does your child eat meat (like fish, pork, chicken and/or beef)?	Yes	No
Does your child get at least 3 servings of milk or other calcium-containing foods daily?	Yes	No

_____

Physical Activity

Does your child typically watch MORE than 2 hours of TV / Computer / Video games, etc. daily?	No	Yes
Is there a television/computer in your child's bedroom?	No	Yes
Has your child fainted while exercising?	No	Yes
Does your child cough or have shortness of breath with exercise?	No	Yes
Has your child had a significant head injury in past 2 years?	No	Yes
Has a family member died suddenly with exercise?	No	Yes
Does your child get at least one hour of moderately strenuous activity most days?	Yes	No

_____

Oral Health

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

_____

Sleep

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

If so, please describe:

_____

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Safety

Do you monitor your child's television and internet use?	Yes	No
Does your child wear a helmet when skiing/biking/skating?	Yes	No
Does your child wear a seatbelt or sit in a booster in the car?	Yes	No
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
Have you discussed stranger awareness with your child?	Yes	No
Does your child know how to use 911 in an emergency?	Yes	No
Are there guns in the home or any home your child regularly visits?	No	Yes
Do you have concerns that your child is being abused?	No	Yes

Mental Health

Do you have concerns about your child's mood (anxiety, depression)?	No	Yes
Do you have concerns about your child's relationship with parents or siblings?	No	Yes
Do you have concerns about how to discipline /set appropriate limits for your child?	No	Yes
Do you or any immediate family members have a history of mental health issues?	No	Yes

If yes, 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
Since your child's last well check has a family member or contact had a positive tuberculosis test?	No	Yes
Was your child born in a high-risk country (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?	No	Yes
Has your child traveled to (or had contact with people who live in) a high-risk country for more than one week (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?	No	Yes

Do you have any concerns about your child's development or any other concerns you would like to discuss with your provider?

_____

_____

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OBERLIN ROAD PEDIATRICS

Well Child Check: 06 - 12 Year Visit

SOCIAL DETERMINANTS OF HEALTH

There are programs to help people with needs that can affect their health, but they aren't reaching everyone who may need them. Are there things you need help with?

Food

Within the past 12 months, did you worry that your food would run out before you got money to buy more?	No	Yes	
Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	No	Yes	

Interpersonal Safety

Do you feel physically or emotionally unsafe where you currently live?	No	Yes	
Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?	No	Yes	
Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	No	Yes	