# 6-8 YEAR OLD

NAME _____
DATE _____

pediatrics NORTHWEST PS
Mary Bridge Children's
www.pedsnw.net

## MEDICAL HISTORY

No — Has your child had any reactions to medications or immunizations?
Select — Does your child take any medications (daily or as needed)?
Select — Is your child currently taking any vitamins, supplements, "alternative medicines" or therapies?
Select — Are there any major illnesses in the family? Which ones? _____
Select — Are there any major changes or stresses in the family (moves, deaths, separation, etc)?
Select — Has your child ever been diagnosed with an immunodeficiency?
Select — Has your child had any illnesses, hospitalizations, or surgeries that we are not already aware of?

## NUTRITION

Select — Does your child get at least 4-5 servings of fruits/vegetables each day?
Select — Does your child get at least 2-3 servings of calcium each day? (milk, cheese, yogurt or calcium supplements)?
Select — Does your child drink anything other than milk and water?
_____ — How many times per week does your child eat fast food?

## PREVENTIVE HEALTH

Select — Has your child seen a dentist in the past 6 months?
Select — Does your child always ride in a booster seat?
Select — Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?
Select — Have those alarms been checked in the past 12 months?
Select — Does your child always use a helmet when riding a bike, skateboarding, or rollerblading?
Select — If you own firearms, are they always locked up?
Select — Does your child live with anyone who smokes?
Select — Has your child had close contact with anyone who has tuberculosis (TB), or is at high risk for TB (anyone who has lived in a developing country, been institutionalized, homeless, IV drug user, HIV positive)?
_____ — How many hours of recreational screen time per day (internet, mobile apps/games, video games, TV, movies, etc.)?
Select — Do you have any concerns about your child's sleep or sleep habits?

## REVIEW OF SYSTEMS *(Does your child have any **CURRENT** problems with the following?)*

Select — headaches, fainting, dizziness, any loss of consciousness, or history of concussion
Select — eyes (crossing, poor vision, etc)
Select — ears, hearing, nosebleeds, or snoring disrupting sleep
Select — coughing, breathing, shortness of breath, wheezing, limited endurance, or chest pain
Select — frequent stomachaches, vomiting, diarrhea, constipation, or blood in the stools
Select — urination (change in frequency, or blood in the urine)
Select — coordination or extremities (feet, legs, arms, hands)
Select — Has your child received blood, plasma, respigam, or gammaglobulin?

**Please continue on the other side.**

**DEVELOPMENT** (please check the things that your child is currently doing)

| | |
|---|---|
| Gross motor | ☐ throws & catches ball ☐ skips ☐ rides a bike |
| Fine motor | ☐ prints well ☐ ties shoelaces |
| Language | ☐ speech clear ☐ can tell a story |
| Cognitive | ☐ sense of humor ☐ recognizes letters ☐ does chores ☐ tells time ☐ reading |

**ACADEMIC**

What school does your child attend?_____ What grade level? _____
How is school going? _____

**VISION/ HEARING VISION/ HEARING**

Per recommendations by the American Academy of Pediatrics (AAP), our providers will routinely order a vision screen and a hearing screen unless your child had one within the past 12 months. These are separate charges in addition to the Well Child visit charge. A few insurance plans do not cover hearing and vision screenings. We strongly recommend that you review your insurance plans coverage prior to your appointment.

If your child has had a hearing or vision screen in the past 12 months, please indicate below:

Recent Hearing Screen Date _____ Recent Vision Screen Date _____

☐ I prefer that my child NOT receive a Hearing or Vision screen today. (Please select one or both) Select

**CONCERNS**

Select Do you have any special concerns today?