6-10 YEAR OLD

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

Patient Name: _____

Person Filling Out Form: _____

Relationship to Patient: _____

CONCERNS

yes no Do you have any questions or concerns about your child's health, development, or behavior?

MEDICAL HISTORY

yes no Does your child take any medications (daily or as needed)? If so, please list: _____
yes no Has your child had any reactions to medications?
yes no Is your child currently taking any vitamins, supplements, "alternative medicines", or therapies?
yes no Are there any major changes or stresses in the family (moves, deaths, separation, etc.)?
yes no Has your child had any new illnesses, ER visits, hospitalizations, or surgeries since their last visit?
yes no Has a parent or household member ever had a problem with alcohol or drug use?
yes no Is there any new information to add to family medical history since the last well child visit?

NUTRITION

yes no Does your child get at least 4-5 servings of fruits/vegetables each day?
yes no Does your child get at least 2-3 servings of calcium each day? (milk, cheese, yogurt or calcium supplements)?
yes no Does your child drink anything other than milk and water? If so, what? _____
_____ How many times per week does your child eat fast food?
_____ How many times per week does your family eat meals together?

PREVENTIVE HEALTH

yes no Has your child seen a dentist in the past 6 months?
yes no Does your child brush their teeth twice daily?
yes no Does your child always ride in a booster seat in the backseat?
yes no Does your child get 10 or more hours of sleep each night?
yes no Is your child watching more than 2 hours of screen time per day (TV, tablet, phone, movies, video games, etc.)?
yes no Does your child have outdoor time daily?
yes no Does your child always use a helmet when using a bike, a scooter, a skateboard, or skiing?
yes no Does your child live with anyone who smokes, vapes, or uses e-cigarettes?
yes no Are there smoke alarms, fire extinguishers, and carbon monoxide alarms in your home?
yes no Have those alarms been checked in the past 12 months?
yes no N/A If you own firearms, are they always locked up and ammunition stored separately?
yes no Has a family member or close contact had tuberculosis or had a positive test for tuberculosis?
yes no Was your child born in or traveled to a country for more than a week that may have a higher risk of tuberculosis and had contact with the resident population (countries outside the United States, Canada, Australia, New Zealand, or Western European countries)?

On average, how difficult was it for your family to meet expenses for basic needs like food, housing, and/or utilities in the past year? (Please circle one that most applies):

Never Seldom Some of the time Most of the time

REVIEW OF SYSTEMS *(CIRCLE ANY **CURRENT** CONCERNS YOU WOULD LIKE TO DISCUSS TODAY)*

yes no Headaches, fainting, dizziness, or any loss of consciousness
yes no Eyes (crossing, poor vision, etc.)
yes no Ears, hearing, nosebleeds, or snoring disrupting sleep
yes no Coughing, breathing, shortness of breath, wheezing, limited endurance, or chest pain
yes no Frequent stomachaches, vomiting, diarrhea, constipation, or blood in the stools
yes no Urination (change in frequency, or blood in the urine)
yes no Coordination or extremities (feet, legs, arms, hands)

Please continue on the other side.

ACADEMIC

What school does your child attend? _____ What grade level? _____

yes no Is your child involved in extracurricular activities? Which ones? _____

yes no Does your child receive any extra services? Please circle: tutoring, PT, OT, speech therapy, etc.

yes no Does your child have a 504 plan or IEP?

yes no Do you or the school have any concerns about your child's academics or behavior?

VISION/ HEARING

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 _____