11 years and Older – Well Child Care Name:______________________

Household

Who lives in the home (e.g. Father, mother, brother, etc.)? ________________________________

Development

Doing well in school	Yes	No
Maintains Friendships	Yes	No
Behavior at home and in school considered Acceptable by others	Yes	No
Engages in regular exercise	Yes	No
Television watching less than 2 hours/day	Yes	No

Please list after school activities including work and sports:____
____

Are you dating?	Yes	No
Do you have questions about Alcohol, Drugs, or Sexual issues	Yes	No

Nutrition

Eats three meals per day with snacks	Yes	No
Drinks skim,1-2% milk	Yes	No
Eats relatively well balanced diet	Yes	No
Well water or city water?	Well	City

Bowel Habits

Every day or every other day stool	Yes	No
Stooling is painless and non-bloody	Yes	No

Safety

Wears a seat belt in automobile	Yes	No
Wears a helmet when cycling/boarding/skating?	Yes	No
Are there smoke detectors in your house	Yes	No
Is your child exposed to tobacco smoke?	Yes	No
Are there any improperly stored firearms in the home?	Yes	No
Is the hot water temperature set low enough to prevent accidental burns?	Yes	No
Are there working smoke detectors in the home?	Yes	No

Any questions or concerns?
If yes, what are they?

Please circle any of the questions below to which your answer is "YES".

Tuberculosis Risk Assessment:

- Was your child born in, or lived more than a year in a country other than the U.S.?
- Has your child been exposed to anyone with either active or a history of Tuberculosis disease?
- Is your child living in a house hold with anyone who is HIV Positive?
- Is your child part of a migrant worker family?

Heart Disease/Cholesterol Risk Assessment:

- Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?
- Has the child's mother or father been diagnosed with high cholesterol? (240 mg/dL or higher)
- Is the child/adolescent overweight?
- Does the patient have a history of smoking?
- Does the patient have a history of Lack of physical activity?
- Does the patient have a history of High blood pressure?
- Does the patient have a history High cholesterol?
- Does the patient have a history Diabetes Mellitus?

Below this line is for Office Use:

Weight ____

Height ____

Head Circumference ____

Blood Pressure ____

Vision Test: Left 20/ ___ Right 20/___

Hearing Test: