



# Well Child Health Screen: 9-10 Years

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Visit Date: \_\_\_\_\_

## General Health Updates

Who is completing this form?	<input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Other, please list:
Any questions, concerns, or problems you want to discuss today?	
Any updates to the patient's health? (i.e. new conditions, surgeries, etc.)	
Any family health, family status or social updates we should be aware of?	
Any concerns about development, learning or behavior?	
Who lives with the patient?	
Any smoke or e-cigarette exposure?	
Anything else you want to share? (milestones, proud moments, etc.)	

## Health Risk Screening

The following questions may prompt your provider to complete further testing, depending on the answer. Ask your provider if you have any questions about these health screening questions.

Have they seen an eye doctor in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have concerns about their hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any concerns about low iron levels or anemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have a parent with elevated blood cholesterol level ( $\geq 240$ mg/dL) or who is taking cholesterol medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

## Family Life

Are there barriers that prevent you from spending time each day interacting with them?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does anyone in the home/family have problems with drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline

## Nutrition

Do you have concerns or questions about what or how they are eating?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you eat together as a family?	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
How often do they drink caffeine, soda or other sugary drinks?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely <input type="checkbox"/> Never

## Oral Health

Do they have any current dental decay/cavities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Do they take extra fluoride OR drink water that contains fluoride?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Do they brush their teeth at least twice a day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you interested in having fluoride varnish applied during this visit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Maybe
Have they been to a dentist in the last 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

### Sleep

Healthy sleep is important for growth, development, and learning. Infants and toddlers may sleep 15-18 hours in a day, while school-aged children should be getting more than 10 hours a day. We do not recommend having a screen in their bedroom as this can affect sleep.

Do you have any concerns about the amount or quality of their sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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### Activity & Screen Time

Is the patient vigorously active for at least one hour a day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Does the patient spend more than two hours a day in front of a screen that is not related to schoolwork?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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### School

Learning and socialization are a critical part of development and the skills learned there will continue to be used throughout their life. Talk to your provider if you have any specific concerns, make sure to mention if the patient is on an IEP or has a 504 for extra support.

What grade are they in and what school do they attend?	
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Do they enjoy school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you have any concerns about their relationships and involvement at school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do they have any learning difficulties at school (such as poor grades or support already in place like tutoring, an IEP or 504)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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### Safety

Do you have questions about what to do when they outgrow their current car safety seat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you use sunscreen regularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you have questions about how to keep them safe around water?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do they wear a helmet every time they ride a bike, scooter, skateboard, ski/snowboard?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If you have guns in your home, are they stored safely (locked with ammunition stored separately)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't have guns
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Have you talked to them about what to do if they encounter a gun?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Have you talked to them about personal boundaries and asked them to come to you if something inappropriate happens?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Have you talked with them about safe and appropriate use of social media/internet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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### Sexuality

Have you talked to them about how their body will change during puberty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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