

Four Seasons Pediatrics
Well Visit Form for 6 Year to 11 Year Well Visit

Child's Name: _____ Birth Date: _____ Age: _____
Today's Date: _____

Any change in address, if so list new information:

School:

School District: _____
Name of School: _____ Grade: _____

School Issues – please check off all that are true:

- Misses less than 2 days each month
- Currently doing well in school
- An adult is at home when he/she returns home from school
- Had a vision and hearing test in school within the last year – If yes was it normal _____

Behavior – please check off all that are true:

- Gets along with children his/her age
- No issues with bad behavior that needs to change
- Does not have to be spanked frequently
- No serious family problems

Illnesses:

If your child is on medicines, name them: _____
Has your child had any serious illnesses since the last check up? _____

Other issues – please check off all that are true:

- Both parents are living at home
- Brushes his/her teeth daily
- Taking fluoride

Screening – Please check the box if any of the following are true:

- My child has had exposure to tuberculosis or a person with a positive skin test
- There is a family history of high cholesterol of > 240 in either parent or grandparents
- There is a family history of heart disease before 55 in either parent or grandparents