Four Seasons Pediatrics

Well Visit Form for 6 Year to 11 Year Well Visit

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

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:

- Has your child had any serious illnesses since the last check up? _____

Social:

- Do you have any concerns about meeting your daily needs, paying for medications, household income, food or housing, crime or other social and economic issues? _____
- Does anyone in the family have any vision, hearing or cognitive problems that would hinder communication with the medical provider? _____
- There are concerns with family mental health, substance abuse or firearms in the home. _____

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

Vaccine Information Statements (Check One)

[ ] I will review the in-room copy
[ ] I will review the on-line copy at your website
[ ] I would like a paper copy