Sutter Health

Well Child Check: School Aged Child (6-12 years)

Your Child's Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT ALL PAGES.

Please list all the medications, vitamins, inhalers or supplements your child is currently taking:

_____

Please list your child's medication or food allergies, if any:_____

Has your child had any major medical problems since their last check up?	No	Yes
Do you have concerns about your child's hearing?	No	Yes
Do you have concerns about your child's vision?	No	Yes

Are Parent(s): Married Unmarried Single Separated Divorced Other: _____
Who lives with your child? Please list (mother, father, grandfather, sister, aunt, etc.)

_____

Does anyone who lives with your child smoke?	No	Yes

SCHOOL

Current grade/ Name of school: _____			
Do you have concerns about your child's school performance?	No	Yes	Unsure
Has your child's teacher raised concerns about your child's school performance?	No	Yes	Unsure
Do you have concerns about your child's interactions with peers at school?	No	Yes	Unsure
Please list any activities your child participates in after school or on weekends: _____			

NUTRITION

Does your child drink more than 6 oz. of juice/ soda/ sports drinks daily?	No	Yes	Unsure
Is your child a vegetarian?	No	Yes	Unsure
Does your child get at least 3 servings of milk or other calcium-containing foods daily?	Yes	No	Unsure

PHYSICAL ACTIVITY

Aside from homework, how many hours a day does your child use a TV, computer or electronic device such as a tablet or cell phone?	0-2	2-4	4+
Does your child play on a school or club team? If yes, what sport(s)? _____	Yes	No	Unsure
Does your child get at least one hour of moderately strenuous activity daily?	Yes	No	Unsure

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SPORTS PRE-PARTICIPATION QUESTIONS:

Has a medical professional ever denied or restricted your child from participating in sports for any reason?	No	Yes	Unsure
Has your child had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused them to miss a practice or a game?	No	Yes	Unsure
Does any injury continue to bother your child?	No	Yes	Unsure
Has your child had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	No	Yes	Unsure
Has your child ever had a seizure?	No	Yes	Unsure
Does your child cough, wheeze, or have difficulty breathing during exercise?	No	Yes	Unsure
Has your child been hospitalized or had heart problems due to COVID-19 infection?	No	Yes	Unsure
Has your child ever passed out or nearly passed out during or after exercise?	No	Yes	Unsure
Has your child ever had discomfort, pain, tightness, or pressure in the chest during exercise?	No	Yes	Unsure
Has your child felt their heart race, flutter or skip beats (irregular beats) during exercise?	No	Yes	Unsure
Has a medical professional ever told you that your child has any heart problems?	No	Yes	Unsure
Has a medical professional ever requested a test for your child's heart? Like an electrocardiogram (EKG) or echocardiogram?	No	Yes	Unsure
Has a family member or relative died of heart problems or had an unexpected sudden death before age 35 (including drowning or unexplained car crash)?	No	Yes	Unsure
Does your child have a family history of a genetic heart problem such as: *hypertrophic cardiomyopathy* (HCM), *Marfan syndrome*, *arrhythmogenic right ventricular cardiomyopathy* (ARVC), *long QT syndrome* (LQTS), *short QT syndrome* (SQTS), *Brugada syndrome*, or *catecholamine polymorphic ventricular tachycardia* (CPVT)?	No	Yes	Unsure
Does your child have a family member with a pacemaker or implanted defibrillator before age 35?	No	Yes	Unsure
Does your child have a family member with sickle cell trait or disease?	No	Yes	Unsure
Has your child experienced any other problems that might affect athletic participation such as recurrent infectious skin rashes, groin pain, absent kidney or testicle, vision problems or heat intolerance?	No	Yes	Unsure

ORAL HEALTH

Does your child see a dentist at least once a year (every 6 months is best)?	Yes	No	Unsure
Does your child brush teeth at least two times daily?	Yes	No	Unsure

SLEEP

Does your child snore on a regular basis?	No	Yes	Unsure
Does your child get at least 8 hours of sleep on a typical school night?	Yes	No	Unsure
Do you have any other concerns about your child's sleep, such as bedwetting? If so, please describe: _____	No	Yes	Unsure

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SAFETY

Do you monitor your child's television and internet use?	Yes	No	Unsure
Does your child wear a helmet when skiing/biking/skating?	Yes	No	Unsure
Does your child wear a seatbelt or sit in a booster in the car?	Yes	No	Unsure
Do you usually protect your child with sunscreen/hats/other measures when outdoors?	Yes	No	Unsure
Does your child know how to stay safe around water? (pool, rivers, etc.)	Yes	No	Unsure
Have you discussed stranger awareness with your child?	Yes	No	Unsure
Does your child know how to use 911 in an emergency?	Yes	No	Unsure
Are there guns at your home, or any home your child regularly visits?	No	Yes	Unsure
Do you have concerns that your child is being abused?	No	Yes	Unsure

MENTAL HEALTH SCREENING

Do you have concerns about your child's mood (anxiety, depression)?	No	Yes	Unsure
Do you have concerns about your child's relationship with parents or siblings?	No	Yes	Unsure
Do you have concerns about how to discipline/set appropriate limits for your child?	No	Yes	Unsure

MENSTRUATION (PERIOD) QUESTIONS

Has your child had their first period?	No	Yes	
If yes, do you or your child have any questions about their periods?	No	Yes	

_____

RISK ASSESSMENT FOR TUBERCULOSIS EXPOSURE / INFECTION:

Was your child born outside of the United States?	No	Yes	Unsure
If so, where? _____			
Has your child ever spent more than a month in any country outside of the United States?	No	Yes	Unsure
If so, where? _____			
Is your child immunosuppressed – currently or planned?	No	Yes	Unsure
Has your child been in close contact with someone with active tuberculosis (TB)?	No	Yes	Unsure

Risk Assessment for Abnormal Lipid Profile (such as high cholesterol):

Did any of your child's parents or grandparents have significant heart disease at or before 55 years of age (had a heart attack, stroke, angioplasty, angina, or bypass surgery)?	No	Yes	Unsure
Do either of the child's parents have a cholesterol level of 240 or higher?	No	Yes	Unsure
Do you have any other concerns you would like to discuss today?	No	Yes	
If yes, please describe: _____			