UW Medicine
PRIMARY CARE

9-10 Year-Old Well Child Visit

Child's Name_____ Child's Age_____ Date_____

Person completing the form_____ Relationship to the patient_____

Has your child had any illnesses, hospitalizations, or surgeries since last visit here? (YES) (NO)

Nutrition:	**Yes**	**No**
Is your child drinking low-fat milk, limited to no more than 2-3 cups per day?	( )	( )
Is juice or sugary drinks limited to 0-1 servings per day?	( )	( )
Does your child eat a variety of fruits/vegetables/dairy/meat?	( )	( )
Does your child regularly take a supplement that contains vitamin D?	( )	( )
On average, does your child eat fast food one or more times per week?	( )	( )

Family and Social History:	**Yes**	**No**
Are there any major illnesses in the family that we are not already aware of?	( )	( )
Is there any family history of sudden cardiac death or arrhythmias?	( )	( )
Are there any major stressors in the family (illness, moves, death, separation)?	( )	( )

Preventative Health/Risk Factors:	**Yes**	**No**
Is screen time (TV/videos/video games/computer/tablet/phone) limited to less than 2 hours a day?	( )	( )
Does your child have a TV or internet in the bedroom?	( )	( )
Does your child always ride in the back seat with a seatbelt?	( )	( )
Do you, anyone who cares for your child, or anyone in your home smoke?	( )	( )
Does your child wear a helmet when riding a bike, skateboarding, rollerblading, etc.?	( )	( )
Are there any guns in the home?	( )	( )
• If yes, are they always kept empty and locked?	( )	( )
Are there smoke detectors and fire extinguishers in the home?	( )	( )
• Are they checked yearly?	( )	( )
Has your child had close contact with anyone who has tuberculosis (TB), or is at high risk for TB (visited Africa, Asia, Latin America, Caribbean Country, been homeless or jailed, IV user, HIV positive)?	( )	( )
Does your child see a dentist twice a year and brush teeth daily?	( )	( )
Is your child getting daily exercise?	( )	( )

Behavioral/Mental Health:	**Yes**	**No**
Does your child have a regular sleep routine?	( )	( )
Does your child sleep well, without snoring?	( )	( )
Do you have any concerns about how your child is learning, developing and behaving?	( )	( )

Academic:	**Yes**	**No**
What grade is your child in?	( )	( )
Is your child scoring at or above grade level?	( )	( )
Does your child enjoy reading?	( )	( )
Is your child involved in extracurricular activities?	( )	( )
Does your child receive extra services, tutoring, PT, OT, speech therapy, etc.?	( )	( )

Puberty:	**Yes**	**No**
Has your child started to have periods?	( )	( )
If yes are they regular and minimally uncomfortable?	( )	( )