

# 7-8-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)

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

<b>Family and Social History:</b>	<b>Yes</b>	<b>No</b>
Are there any major illnesses in the family that we are not already aware of?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any major stressors in the family (illness, moves, death, separation)?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Preventative Health/Risk Factors:</b>	<b>Yes</b>	<b>No</b>
Does your child always ride in a car seat or booster seat, in the back seat?	<input type="checkbox"/>	<input type="checkbox"/>
Is screen time (TV/videos/video games/computer/tablet/phone) limited to less than 2 hours a day?	<input type="checkbox"/>	<input type="checkbox"/>
Do you, anyone who cares for your child or anyone in your home smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have a TV or internet in the bedroom?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child wear a helmet when riding a bike, skateboarding, rollerblading, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any guns in the home?	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, are they always kept empty and locked?	<input type="checkbox"/>	<input type="checkbox"/>
Are there smoke detectors and fire extinguishers in the home?	<input type="checkbox"/>	<input type="checkbox"/>
• Are they checked yearly?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child getting exercise?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Oral Health:</b>	<b>Yes</b>	<b>No</b>
Does your child see a dentist twice a year and brush teeth daily?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Behavioral/Mental Health:</b>	<b>Yes</b>	<b>No</b>
Does your child have a regular sleep routine?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child sleep well, without snoring?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child wet the bed regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any concerns about how your child is learning, developing and behaving?	<input type="checkbox"/>	<input type="checkbox"/>

PLACE PATIENT LABEL HERE

**UW Medicine**

Harborview Medical Center – University of Washington Medical Center  
UW Medicine Primary Care – Valley Medical Center – UW Physicians

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Developmental Surveillance:

<b>Learning Skills:</b>	<b>Yes</b>	<b>No</b>
Doing well in school?	<input type="checkbox"/>	<input type="checkbox"/>
Does chores when asked?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Social/Emotional Development:</b>	<b>Yes</b>	<b>No</b>
Have friends?	<input type="checkbox"/>	<input type="checkbox"/>
Gets along with family?	<input type="checkbox"/>	<input type="checkbox"/>

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