Child's name_____ Date of birth _____ Today's Date _____
(first last)

Screening for Child Age 5 - 10 years

Age ___Years

Nutrition	How many ounces of milk per day	None 4 8 16 24 >25
	What type of milk	Whole 2% 1% Skim Soy Rice Other
	How many ounces of juice per day	None 4 8 16 24 >25
	How many ounces of water per day	None 4 8 16 24 >25
	How many caffeinated drinks per day	None 1 2 3 4 5
	Eats regular meals including fruits/vegetables	Yes No
	Protein Source	Red Meat Chicken Turkey Fish

Education	School Grade	Pre-K Kinder 1st 2nd 3rd 4th 5th
	Special Education	No Yes
	School Performance	A B C D F other
	Parent/teacher concerns	No Yes
	Behavior concerns	No Yes
	Attention	Normal Abnormal
	Homework	Normal Abnormal
	Social Interaction	Normal Abnormal

Well Child	Sleeping Concerns	No Yes
	Behavior/Attention	Normal Abnormal
	Has friends	Yes No
	At least 1 hour of physical activity per day	Yes No
	Less than 2 hours screen time per day	Yes No
	Does your child wear a helmet with riding a bicycle, skateboard, etc.	Yes No
	Do you have a swimming pool	No Yes
	Car Safety	Car Seat Booster Seat Seat Belt
		Back Seat Front Seat
	Brushes teeth	Twice/day Once/day

Has your child been diagnosed with Asthma?	No Yes
When was your child last Influenza Vaccine?	Date:

Date: _____

Patient Name: _____ **DOB** _____

HISTORY FORM

Is there any <u>family history</u> of:

		NO	YES
1.	Sudden death from heart disease before age 50?	☐	☐
2.	Disability from heart disease before age 50?	☐	☐
3.	Long Q-T Syndrome, Cardiomyopathy, or Marfan syndrome?	☐	☐
4.	High Blood Pressure? Who? ☐ father ☐ mother ☐ grandparent	☐	☐
5.	High Cholesterol? Who? ☐ father ☐ mother ☐ grandparent	☐	☐
6.	Diabetes? Who? ☐ father ☐ mother ☐ grandparent	☐	☐

Is there a <u>patient history</u> of:

1.	Chest pain with exercise?	☐	☐
2	Excessive fatigue or shortness of breath with exercise?	☐	☐
3.	Fainting?	☐	☐
4.	Heart murmur?	☐	☐
5.	High blood pressure?	☐	☐

Please explain "YES" answers here:

_____

_____

Who lives in the home with the patient:

_____

TURN OVER

TO BE ANSWERED BY PATIENT:

In the past two weeks, how often have you been bothered by:

1. Little interest or pleasure in doing things?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly ever day

2. Feeling down, depressed, hopeless?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly ever day

Have you ever been concerned about someone in your family who is drinking alcohol or using drugs?
☐ Yes ☐ No

Are you exposed to tobacco smoke or chewing tobacco?
☐ Yes ☐ No

Do you live with anyone who uses tobacco?
☐ Yes ☐ No

Are any of your friends using tobacco or e-cigarettes?
☐ Yes ☐ No