Pediatrics Southwest

HEALTH UPDATE SHEET
6 YEARS TO 11 YEARS
MARK D. TOWNS, M.D.

Child's Name: _____

Date of Birth: _____

INSTRUCTIONS:

In order to give your child the best care and to help identify your concerns, please answer the following questions. Find the column for your baby's age and fill in today's date. Answer each question by circling yes or no in the appropriate column. If you cannot answer the question, just move to the next one.

CHILD'S CURRENT AGE ⇒	6-7 YRS		8-9 YRS		10-11 YRS	
TODAY'S DATE ⇒						
Do you have any special questions or worries you would like to discuss today?	Yes	No	Yes	No	Yes	No
SINCE HIS/HER LAST WELL-CHILD CHECKUP HERE, HAS YOUR CHILD…						
1. Been seen by a doctor, clinic or other specialist besides at this office?	Yes	No	Yes	No	Yes	No
2. Had any bad reactions to shots, food or medicine?	Yes	No	Yes	No	Yes	No
3. Experienced any important changes for the family - moves, job loss, serious illness, family problems, new baby, etc.?	Yes	No	Yes	No	Yes	No
SINCE HIS/HER LAST WELL-CHILD CHECKUP, DOES YOUR CHILD…						
4. Seem to have trouble hearing?	Yes	No	Yes	No	Yes	No
5. Seem to have trouble seeing or have eyes that turn in or out?	Yes	No	Yes	No	Yes	No
6. Have ear trouble or infections?	Yes	No	Yes	No	Yes	No
7. Have frequent colds, runny nose, sore throat or cough?	Yes	No	Yes	No	Yes	No
8. Usually breathe with his/her mouth open or snore?	Yes	No	Yes	No	Yes	No
9. Ever wheeze or have trouble breathing?	Yes	No	Yes	No	Yes	No
10. Have problems with stomach or bowels?	Yes	No	Yes	No	Yes	No
11. Have urine infections or problems?	Yes	No	Yes	No	Yes	No
12. Have seizures, convulsions, or blackouts?	Yes	No	Yes	No	Yes	No
13. Complain of frequent aches and pains?	Yes	No	Yes	No	Yes	No
14. Seem unusually tired?	Yes	No	Yes	No	Yes	No

Please continue on the other side

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CHILD'S CURRENT AGE ⟹
TODAY'S DATE ⟹

6-7 YRS	8-9 YRS	10-11 YRS
15. Go to a dentist regularly? No Yes	No Yes	No Yes
16. Eat many sweet, sodas, or other "junk food"? Yes No	Yes No	Yes No
17. Does he/she eat a variety of foods including representatives from each of the following:		
Rice, cereal, breads, or pasta? No Yes	No Yes	No Yes
Fruits and vegetables? No Yes	No Yes	No Yes
Milk, cheese, yogurt, and meats? No Yes	No Yes	No Yes
18. Always use a seat belt in the car? No Yes	No Yes	No Yes
19. Is your child generally happy and easy to be with? No Yes	No Yes	No Yes
20. Does he/she get along well with other children? No Yes	No Yes	No Yes
21. Is he/she in the right grade for age? No Yes	No Yes	No Yes
22. Does he/she need any special help or special classes in school? Yes No	Yes No	Yes No
23. Does he/she enjoy school? No Yes	No Yes	No Yes
24. Are there any school problems? Yes No	Yes No	Yes No
25. Are you concerned about your child's behavior in any way? Yes No	Yes No	Yes No
26. Does your child ride bikes, horses, scooters, or skates? Yes No	Yes No	Yes No
27. Does your child know his/her phone number, address, and basic fire safety rules? No Yes	No Yes	No Yes
28. Have you discussed "stranger awareness" with your child? No Yes	No Yes	No Yes
29. Estimate the number of hours a day your child watches television		
30. Have you discussed sexual matters, including A.I.D.S with your child? No Yes	No Yes	No Yes

31. Which of these have been problems? (circle)

Won't mind	Trouble sleeping	Lying	Bad Temper
Too active	Nightmares	Stealing	Cries too much
Easily upset	Fights too much	Jealousy	Accident prone
Too shy	High strung/nervous	Sad a Lot	