

Name: _____ DOB: _____ Today's Date: _____



EIGHT YEAR WELL CHILD CHECK

INTERVAL HISTORY

Any changes in your family since last visit? <input type="checkbox"/> Move <input type="checkbox"/> Job change <input type="checkbox"/> Divorce <input type="checkbox"/> None <input type="checkbox"/> Other:	
Any relatives diagnosed with new medical issues since last visit? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:	

BEHAVIORAL / DEVELOPMENTAL SURVEILLANCE

Any concerns about your child's growth / learning / behavior?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:
Mark the tasks that your child can do: <input type="checkbox"/> Eats healthy <input type="checkbox"/> Doing well in school <input type="checkbox"/> Is physically active for 1 hour a day <input type="checkbox"/> Gets along with family <input type="checkbox"/> Has friends <input type="checkbox"/> Does chores when asked <input type="checkbox"/> Participates in after-school activity	

ANEMIA / TB / CHOLESTEROL / FLUORIDE RISK ASSESSMENT

Does your child eat a strict vegetarian diet?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If your child is a vegetarian, does he/she take iron supplement?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Was your child born in a country where tuberculosis is prevalent (outside the US)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has your child traveled (>1 week) to a country at high risk of tuberculosis?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has your child had contact with anyone with tuberculosis or a positive PPD test?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is your child infected with HIV?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child have parents or grandparents who've had stroke or heart problems before age 55?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child have a parent with high cholesterol (>240 mg/dL) or taking cholesterol medication?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your primary water source have fluoride (i.e. city water)?	<input type="checkbox"/> No <input type="checkbox"/> Yes

ANTICIPATORY GUIDANCE:

- Eat together as a family. Limit sodas, juice,, chips, sweets. Eat at least 5 servings of veggies and fruits daily.
- Drink low-fat or skim (fat-free) milk at last 3x a day. If lactose intolerant, drink soy or lactose-free milk.
- Limit TV and computer time to 2 hours a day. Stay active for at least 1 hour a day.
- Your child should ride in the back seat and use a booster until the vehicle's seat belt fits.
- Teach your child to swim to prevent drowning. Use sunscreen when outside.
- Watch your child's computer use. Know who he/she talks to online. Install a safety filter on computer or phone.
- Teach your child emergency plans during fire, tornado, or robbery. Teach your child when and how to dial 911.
- Give your child chores to do and expect them to be done. Be a good role model for your child.
- Help your child to do things for him/herself. Teach him to help others. Discuss rules & consequences with him.
- Talk to your child and teacher about bullying. Know your child's friends and their families.
- Talk with the teacher if you feel your child needs extra help or tutoring.
- Help your child brush teeth twice a day. No food after brushing at night. Floss daily. Visit dentist twice a year.