

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



TEN 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: |
| <p>Mark the tasks that your child can do:</p> <input type="checkbox"/> Eats healthy <input type="checkbox"/> Doing well in school <input type="checkbox"/> Is active for 1 hour/day <input type="checkbox"/> Making some decisions by self <input type="checkbox"/> Has friends <input type="checkbox"/> Feels good about self <input type="checkbox"/> Does after-school activities <input type="checkbox"/> Gets along with family <input type="checkbox"/> Is good at something, describe: | |

ANEMIA / TB / 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 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.
- Talk to your child about not smoking, not drinking alcohol, and not using drugs.
- Teach your child emergency plans during fire, tornado, or robbery.
- Give your child chores to do and expect them to be done. Be a good role model for your child.
- Give your child his/her own space.
- Set routines for completing homework. Provide quiet space where he/she can complete homework without distraction.
- Prioritize school work before anything else.
- Talk to your child and teacher about bullying. Know your child's friends and their families.
- Help your child brush teeth twice a day. No food after brushing at night. Floss daily. Visit dentist twice a year.