Well Child Packet
(3 -10 Years of Age)

Developmental Screening

Patient Name: ______________________________ DOB: _______________ Date: _______________

***If you are a parent filling this out for the patient, please ask the patient the questions and document their answer. This form must be completed before the patient can be seen by a provider. Do not leave blank!

Circle Your Answers

Communication

1. Do you find it difficult to hear? **Yes / No**
2. Do you find it difficult to see? **Yes / No**
3. Do you find it difficult to communicate to others? **Yes / No**

Health

4. Do you like to take showers and/or baths? **Yes / No**
5. How many times to you brush your teeth every day? **1 2 3 More**
6. How many meals do you usually eat every day? **1 2 3 More**

7. Do you like school? **Never / Sometimes / Always**
8. How are your grades? **Poor / Fair / Good**

9. What do you think about alcohol?
   Bad for everyone **OK for grownups** **OK for anybody**
10. What do you think about smoking?
   Bad for everyone **OK for grownups** **OK for anybody**
11. What do you think about drugs?
   Bad for everyone **OK for grownups** **OK for anybody**

Patient Name: ________________________________ **DOB:** ____________________ **Date:** ________________

Lead Risk Assessment

Circle Yes or No.

1. Does your child live in or regularly visit a house/apt. that was built before 1978? ***Yes / No***
2. Does your child live in or often visit a house/apt. that is being remodeled or having paint removed? ***Yes / No***
3. Does your child live with or often visit with a child that had an elevated Blood Lead Level? ***Yes / No***
4. Does your child live with an adult whose job or hobby involves exposure to lead? ***Yes / No***
5. Does your child chew on or eat non-food items such as paint chips or dirt? ***Yes / No***
6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead? ***Yes / No***
7. Does your child receive medicines such as Greta, Azarcon, Kohl or Pay-loo-ay? ***Yes / No***

Tuberculosis (TB) Risk Assessment

Circle Yes or No.

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray? ***Yes / No***
2. Has the child been in close contact to a person sick with active TB disease? ***Yes / No***
3. Was the child born outside the United States or has the child traveled outside the United States? ***Yes / No***
4. Does the child have a household member who was born outside the United States or who has traveled outside the United States? ***Yes / No***
5. Is the child exposed to a person who ***Yes / No***
   - Is currently in jail or who has been in jail in the past 5 years?
   - Has HIV?
   - Is homeless?
   - Lives in a group home?
   - Uses illegal drugs?
   - Is a migrant farm worker?
6. Does the child have HIV, at risk to have HIV or any other health problem that lowers the immune system? ***Yes / No***
7. Is the child/teen in jail or ever been in jail? ***Yes / No***

Hemoglobin Assessment

1. Does the child have history of prematurity or low birth weight? ***Yes / No***
2. Does the child have any feeding problems and/or sudden weight gain or loss? ***Yes / No***
3. Does the child have any chronic disease or major blood loss? ***Yes / No***