MUNDELEIN PEDIATRICS

7-11 Year Well Exam

Name: _____DOB: ____/____/____ Today's Date: ____/____/____

Please circle the answer that most appropriately describes your child:

1. Sleeps through the night: Yes/No Concerns: _____
   (____) hours per night
2. Good eating habits: Yes/No Concerns: _____
3. Urinating well: Yes/No Concerns: _____
4. Normal bowel movements Yes/No Concerns: _____
5. Takes Vitamins: Yes/No Product Name: _____
6. Emergency room visits: Yes/No
7. Illness since last visit: _____
8. Grade level in school: _____; Concerns with school performance_____
9. Extra-Curricular activities: Yes/No
10. Participates regularly in exercise: Yes/No
    Any history of sports injury or concussion: Yes/No
11. Developmentally: appropriate peer interactions, fair-good writing skills, good hand-eye coordination, good physical

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Please circle the answer that most appropriately describes your home environment:

1. Smoke-free home and car: Yes/No
2. Parent smokes outside: Yes/No Mom/Dad/Sibling/Relative/Babysitter
3. Fire arms at home: Yes/No If yes, are safety precaution taken: Yes/No
4. Television /Video game time: Hours per day: _____
5. Rides in the back seat: Yes/No
6. Uses helmet when riding bike, skates and scooters Yes/No
7. Supervised after school None/Parent/Relative/After-school club/Babysitter
8. Primary care taker: Mom/Dad/Grandparents
9. Household composition:
   Adult(Names/Ages): _____

   Children(Names/Ages): _____

10. New health problems in parents or siblings: _____
11. Dental Visits Yes/No
12. Past vaccine reactions: Yes/No
13. Sibling rivalry: Yes/No

Do you have any other concerns you wish to discuss? Yes/No

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