9- 10 YEAR
PEDIATRIC DEVELOPMENTAL SCREENING

Date: ______________________

Name: ______________________________________ DOB:___________ Male Female

Physician Signature:______________________________________

Instructions: Please answer the questions below about your child by choosing YES or NO. These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have any concerns about your child's health?	NO	YES
Feeding/ Nutrition		
Does your child have fruits or vegetables at every meal?	YES	NO
Are you giving your child mostly whole grains?	YES	NO
Is your child drinking milk?	YES	NO
How much milk per day?		
What type of milk?		
Does your family eat junk foods (chips, cookies, crackers,candy) or fast foods daily?	NO	YES
Is your child taking any vitamins or supplements?	YES	NO
Does your child drink juice or other sweetened drinks?	NO	YES
Lipids		
Have any parents or grandparents experienced a stroke or heart attack before age 55?	NO	YES
Do either parent have high cholesterol or are on cholesterol medication?	NO	YES
Oral Health		
Are cavities a problem for you or anyone in your family?	NO	YES
Are you using a soft toothbrush or cloth to clean child's teeth two times a day?	YES	NO
Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
Does your child see a dentist twice per year?	YES	NO
School		
Does your child have problems with progress in school or the ability to learn?	NO	YES
Does your child have problems sitting still or concentrating on schoolwork?	NO	YES
Does your child have problems with the ability to get along with teachers?	NO	YES
Does your child have problems with happiness, self esteem, self-confidence?	NO	YES
Does you child have problems with irritability, temper, outbursts, excessive anger?	NO	YES
Does your child have problems with peer relationships (lack of friends, bullying)?	NO	YES
Activity/Exercise/Screen time		
Does your child watch more than 2 hours of screen time per day(TV, computer, video games)?	NO	YES
Is there a TV or video game system in your child's bedroom?	NO	YES
Does your child play actively at least one hour per day?	YES	NO
Do you encourage family activities such as walking, bicycling, swimming, or dancing?	YES	NO
Do you do educational activities as a family, such as go to museums, zoos, or libraries?	YES	NO
Do you eat meals together as a family?	YES	NO
Do you spend time alone with each of your children?	YES	NO
Do you spend time alone with your partner?	YES	NO

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Social Stressors		
Are you able to take a little time for yourself?	YES	NO
Have you had any major changes or stresses in your family recently?	NO	YES
Do you ever worry your family will go hungry?	NO	YES
Does your partner ever hurt you or your children?	NO	YES
Safety		
Do you have rules about internet safety? Are there parental controls set?	YES	NO
Do you have rules about answering the door and phone at home?	YES	NO
Does your child wear a helmet when biking, skating, skiing, or snowboarding?	YES	NO
Is your child exposed to anyone who smokes?	NO	YES
Is there a gun in the home?	NO	YES
QÁ^•ÊÁs it locked or in a safe place?	ÝÒÙ	ÞU
Do you use sunscreen on your child for prolonged sun exposure?	YES	NO
Does your child use a seatbelt in the car or booster seat if *under* 4 feet 9 inches tall?	YES	NO
Does your home have working smoke detectors and carbon monoxide detectors?	YES	NO
Do you have a home fire escape?	YES	NO
Tuberculosis		
Has a family member or contact had tuberculosis disease?	NO	YES
Has a family member had a positive TB skin test (PPD)?	NO	YES
Was your child born in a high-risk country (countries other that the U.S., Canada, Australia, or Western Europe?	NO	YES
Has you child traveled to a high-risk country for more than a week?	NO	YES
Review of Systems		
Do you have any concerns about		
Eating habits, weight loss, or lack of energy?	NO	YES
Sleep problems, including excessive snoring?	NO	YES
Eye redness, excessive tearing, or discharge?	NO	YES
Recurrent ear, sinus or throat infections, nosebleeds?	NO	YES
Chest pain, shortness of breath, or irregular heartbeat?	NO	YES
Frequent colds, cough, wheezing, recurrent lung infections?	NO	YES
Abdominal pain, vomiting, diarrhea, constipation?	NO	YES
Kidney or bladder problems, infections, blood in the urine?	NO	YES
Birthmarks, skin rashes, itching, nail or hair problems?	NO	YES
Joint pain, stiffness, swelling, muscle pain or weakness?	NO	YES
Recurrent headaches, dizziness, tics, weakness seizures?	NO	YES
Mood changes, sadness, nervous problems?	NO	YES
Excessive thirst or hunger, increase urination?	NO	YES
Paleness, anemia, easy bruising, swollen glands?	NO	YES
Puberty?	NO	YES
FOR GIRLS:		
Has she gotten her period?	NO	YES
Problems or questions about menstruation?	NO	YES