Nataloni Pediatrics
701 Route 25A Suite B3
Mt. Sinai, NY

WELL CHILD CHECK: AGES 6-10

Your Child's Name: _____ Date: _____

Person Completing the Form: _____ Relationship to Child: _____

Has your child had any major medical problems since their last checkup?	Yes	No
Do you have concerns about your child's hearing?	Yes	No
Do you have concerns about your child's vision?	Yes	No

Are parents: Married Separated Divorced Other _____

Does anyone who lives with your child smoke?	Yes	No

SCHOOL

Current grade/ name of school _____

Do you have concerns about your child's school performance?	Yes	No	Unsure
Has your child's teacher raised concerns about your child's performance?	Yes	No	Unsure
Do you have concerns about your child's interactions with peers at school?	Yes	No	Unsure

Please list any activities your child participates in at school or on weekends: _____

NUTRITION

How much juice/soda/sports drinks does your child drink everyday?	_____oz		
Is your child a vegetarian?	Yes	No	
Does your child get at least 4 servings of milk or other calcium containing foods daily?	Yes	No	Unsure

PHYSICAL ACTIVITY

Does your child typically watch MORE than 2 hours of TV/ Computer/ Video-Games, etc, daily?	Yes	No	Unsure
Is there a TV or computer in your child's bedroom?	Yes	No	
Does your child get a least 1 hour of moderately strenuous activity most days?	Yes	No	

ORAL HEALTH

Does your child visit the dentist every six months?	Yes	No	Unsure
Does your child get fluoride daily from water or supplements?	Yes	No	Unsure

Does your child brush their teeth at least two times daily? Yes No

SLEEP

Does your child snore on a regular basis? Yes No Unsure

How many hours per night does your child usually sleep? _____ hours

Do you have any concerns about your child's sleep? Yes No Unsure

If yes, please describe: _____

SAFETY

Do you monitor your child's TV and computer use? Yes No Unsure

Does your child wear a helmet when biking/skiing/skating? Yes No Unsure

Does your child wear a seatbelt or sit in a booster in the car? Yes No Unsure

Does your child usually use sunscreen/ hats/ other sun protection? Yes No Unsure

Does your child know how to stay safe around water (pools, rivers, etc.)? Yes No Unsure

Have you discussed stranger awareness with your child? Yes No Unsure

Does your child know how to use 911 in an emergency? Yes No Unsure

If guns are in the home, are they safely secured? Yes No Unsure

MENTAL HEALTH

Do you have concerns about your child's mood (anxiety, depression)? Yes No Unsure

Do you have concerns about your child's relationship with parents or siblings? Yes No Unsure

Do you have concerns about how to discipline/ set appropriate limits? Yes No Unsure

If yes, please explain: _____

FOR GIRLS ONLY

Has your daughter had her first period? Yes No Unsure

If yes, do you have any questions about her periods? Yes No Unsure

RISK ASSESMENT FOR ABNORMAL LIPID PROFILE (SUCH AS HIGH CHOLESTROL)

Did any of your child's parents or grandparents have significant heart diease at or before 55 years of age (had heart attack, stroke, angioplasty, angina, or bypass surgery)? Yes No Unsure

Do either of the child's parents have high cholesterol level of 240 or higher? Yes No Unsure

Do you have any other concerns you would like to discuss today? Yes No

If yes, what are your concerns: _____

Nataloni Pediatrics, P.C.

Pre-Participation Physical Evaluation

Patient's Name: _____ Date of Birth: _____ Age: _____

The following questions should be completed by student or parent. Please explain "yes" answeres where indicated. Circle questions you don't know answers to.

		Yes	No
1.	Have you had a medical illness or injury since your last check-up or sports physical? If yes, please explain: _____	☐	☐
2.	Do you have an ongoing illness? If yes, please explain: _____	☐	☐
3.	Have you ever been hospitalized overnight? If yes, please explain: _____	☐	☐
4.	Have you ever had surgery? If yes, please explain: _____	☐	☐
5.	Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills, or using an inhaler? If yes, please explain: _____	☐	☐
6.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your Performance? If yes, please explain: _____	☐	☐
7.	Do you have any allergies (for example: to pollen, medicine, food or stinging insects)? If yes, please explain: _____	☐	☐
8.	Have you ever had a rash or hives develop during or after exercise? If yes, please explain: _____	☐	☐
9.	Have you ever passed out during or after exercise? If yes, please explain: _____	☐	☐
10.	Have you ever been dizzy during or after exercise? If yes, please explain: _____	☐	☐
11.	Have you ever had chest pain during or after exercise? If yes, please explain: _____	☐	☐
12.	Do you get tires more quickly than your friends do during exercise? If yes, please explain: _____	☐	☐
13.	Have you ever had racing of your heart or skipped heartbeats? If yes, please explain: _____	☐	☐
14.	Have you ever had high blood pressure or high cholesterol? If yes, please explain: _____	☐	☐
15.	Have you ever been told you have a heart murmur? If yes, please explain: _____	☐	☐
16.	Has any family member or relative died of heart problems or sudden death before age 50? If yes, please explain: _____	☐	☐
17.	Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month? If yes, please explain: _____	☐	☐
18.	Has a physician ever denied or restricted your participation in sports for any heart problems? If yes, please explain: _____	☐	☐
19.	Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus or blisters)? If yes, please explain: _____	☐	☐
20.	Have you ever had a head injury or concussion? If yes, please explain: _____	☐	☐
21.	Have you ever been knocked out, become unconscious or lost your memory? If yes, please explain: _____	☐	☐
22.	Have you ever had a seizure? If yes, please explain: _____	☐	☐

	Yes	No
23. Do you have frequent or severe headaches?	☐	☐
If yes, please explain: _____		
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
If yes, please explain: _____		
25. Have you ever had a stinger, burner or pinched nerve?	☐	☐
If yes, please explain: _____		
26. Have you ever become ill from exercising in the heat?	☐	☐
If yes, please explain: _____		
27. Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
If yes, please explain: _____		
28. Do you have asthma?	☐	☐
If yes, please explain: _____		
29. Do you have seasonal allergies that require medical treatment?	☐	☐
If yes, please explain: _____		
30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position, (for example, knee brace, special neck roll, foot orthotics, retainer for your teeth, hearing aid)?	☐	☐
If yes, please explain: _____		
31. Have you had any problems with your eyes or vision?	☐	☐
If yes, please explain: _____		
32. Do you wear glasses, contacts or protective eyewear?	☐	☐
If yes, please explain: _____		
33. Have you ever had a sprain, strain or swelling after injury?	☐	☐
If yes, please explain: _____		
34. Have you broken or fractured any bones or dislocated any joints?	☐	☐
If yes, please explain: _____		
35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐
If yes, check appropriate blank and explain in the space provided:		
___Head ___Elbow ___Hip ___Neck ___Forearm ___Thigh ___Back ___Wrist ___Knee		
___Chest ___Hand ___Shin/Calf ___Shoulder ___Finger ___Ankle ___Upper Arm ___Foot		
If yes, please explain: _____		
36. Do you want to weigh more or less than you do now?	☐	☐
If yes, please explain: _____		
37. Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
If yes, please explain: _____		
38. Do you feel stressed out?	☐	☐
If yes, please explain: _____		

39. Record the dates of your most recent immunizations (shots) for:

Tetanus: _____

Measles: _____

Hepatitis B: _____

Chickenpox: _____

FEMALES ONLY – Optional –

40. When was your first menstrual period?

_____

41. When was your most recent menstrual period?

_____

42. How much time do you usually have from the start of one period to the start of another?

_____

43. How many periods have you had in the last year?

_____

44. What was the longest time between periods in the last year?

_____

Signature of parent/guardian: _____ Date: _____