Your Child’s 6 Year Well Visit – What to Expect, What to Ask

Your Name: ____________________________________
Your Relationship to the Child: ___________________________

Are there specific concerns you want to discuss today? □ No □ Yes ____________________________________

Have there been any major changes in your family lately? □ None □ Move □ Job Change □ Separation □ Divorce
□ Death in the family □ New pet □ Other? Describe: __________________________________________________

Child lives with? □ Both Parents □ Mother □ Father □ Stepparent □ Grandparent(s) □ Other? _______________________

Total number of adults living in home: ______ Total number of children living in home: ______

Who takes care of your child most days of the week?
□ Mother □ Father □ Other relative (e.g. grandmother) □ Daycare □ Other? Describe: _______________________

In general, how well do you feel you are coping with the day-to-day demands of parenthood?
□ Not well at all □ Not very well □ Somewhat well □ Well □ Very well

General Health Information: Since Your Last Visit

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you or your child had any major illness and/or hospitalizations?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you, anyone in your family, or your child’s relatives developed new medical problems?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child have allergies? If yes, describe:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child take medications regularly? If yes, list here:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have someone you can trust and go to for emotional support?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are yours and your child’s immunizations (includes flu and pneumonia) current?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you or any adults around your child smoke (includes inside or outside the house)?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Would you like to get more information on any of the topics below?

Injury Prevention
- Seat belt/auto safety
- Bicycles/ATV
- Athletics
- Water safety
- Smoke detectors
- Firearm safety

Health Promotion
- Limit TV viewing
- Passive smoking
- Sleep patterns
- Pubertal changes/sexuality
- Dental care/sealants

Behavior
- Substance abuse
- Tobacco use
- Security
- Discipline patterns
- Social interaction
- Responsibility
- Sex education

Nutrition
- Healthy diet/snacks
- Junk Food
- Iron-rich foods
- Healthy weight

Do you have any specific concerns about your child’s learning, development or behavior? □ A lot □ A little □ Not at all
Describe: ____________________________________________________________________________________

Do you have any concerns about your child’s vision (how well your child sees)? □ Yes □ No

Do you have any concerns about your child’s hearing? □ Yes □ No

Please check each task your child is able to do right now.

- Shower/Baths with a little assistance
- Playing fair
- Fix cold cereal
- Age appropriate chores

What to expect at your Child’s Texas Health Steps exam

- Height & Weight
- Lab tests – anemia & blood questions
- Dental Referral
- Blood Pressure
- Vision & Hearing Screening
- Unclothed Physical Exam; Health History
- Immunizations (possibly DTaP, Polio, MMR, Varicella, Hepatitis A, Pneumococcal, Meninogococcal & Influenza)

This is not a self-diagnosis tool or a treatment plan. Please consult your doctor and share this form at your next visit.