

## Your Child's 8 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

<b>General Health Information: Since Your Last Visit</b>	<b>Yes</b>	<b>No</b>	<b>Unsure</b>
Have you or your child had any major illness and/or hospitalizations?			
Have you, anyone in your family, or your child's relatives developed new medical problems?			
Does your child have allergies? If yes, describe:			
Does your child take medications regularly? If yes, list here:			
Do you have someone you can trust and go to for emotional support?			
Are yours and your child's immunizations (includes flu and pneumonia vaccines) current?			
Do you or any adults around your child smoke (includes inside or outside the house)?			

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

<b>Injury Prevention</b>	<b>Health Promotion</b>	<b>Behavior</b>	<b>Nutrition</b>
<ul style="list-style-type: none"> <li>• Seat belt/auto safety</li> <li>• Bicycles/ATV</li> <li>• Athletics</li> <li>• Water safety</li> <li>• Smoke detectors</li> <li>• Firearm safety</li> </ul>	<ul style="list-style-type: none"> <li>• Limit TV viewing</li> <li>• Passive smoking</li> <li>• Regular exercise</li> <li>• Sleep patterns</li> <li>• Pubertal changes/sexuality</li> <li>• Dental care/sealants</li> </ul>	<ul style="list-style-type: none"> <li>• Substance abuse</li> <li>• Tobacco use</li> <li>• Security</li> <li>• Discipline patterns</li> <li>• Social interaction</li> <li>• Responsibility</li> </ul>	<ul style="list-style-type: none"> <li>• Healthy diet/snacks</li> <li>• Junk Food</li> <li>• Iron-rich foods</li> <li>• Healthy weight</li> </ul>

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.

Pack school bag  Use toaster oven  Help around the house ex pick up toys, set table, fold towels, make bed  Memorizing multiplication tables

### What to expect at your Child's Texas Health Steps exam:

Height & Weight  Blood Pressure  Vision & Hearing Screening  Unclothed Physical Exam; Health History  
 Dental Referral  Health History  Immunizations (possibly Polio, MMR, Varicella, Hepatitis A & B, Pneumococcal, Meningococcal & Influenza)

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