



Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**Risk Assessment 6 Year**

Does child brush teeth twice per day Yes No Comment

Does child see dentist at least twice a year Yes No Comment

Servings of fruit & vegetables per day	More than 4 per day	3-4 per day	1-2 per day	0-1 per day
Eats out each week	0-1 times	1-2 times	3-4 times	More than 4 times
Activity level	More than 60 min per day	30-60 min per day	Less than 30 min per day	Not very often
Sweet drinks per day	Not very often	1 per day	2 per day	More than 3 per day
TV/screen time	Not very often	30-60 min/d	1-2hr/d	More than 2hr/d

Draws a person with 6 body parts Yes No Comment

Copies squares, triangles Yes No Comment

Writes some letters and numbers Yes No Comment

Ties a knot Yes No Comment

Balances on one foot Yes No Comment

Hops, skips, climbs Yes No Comment

Counts to 10 Yes No Comment

Names at least 4 colors Yes No Comment

Listens well and follows simple instructions Yes No Comment

Can tell a story in full sentences Yes No Comment

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Have any members of the family or your child's playmates had high blood lead level? No Yes Unknown Comment

Does child live/visit house built before 1978 that is currently being renovated? No Yes Unknown Comment

Does child live/visit a house/apartment/building built before 1950? No Yes Unknown Comment

Born in country outside of the United States No Yes Unknown Comment

Traveled or had contact with high TB risk populations longer than a week No Yes Unknown Comment

Family member or contact had tuberculosis or positive TB skin test. No Yes Unknown Comment

Is the child HIV infected? No Yes Unknown Comment

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Parent or Grandparents have stroke or heart problems No Yes Comment

before age 55

Parent has elevated cholesterol >240mg/dl or is taking No Yes Comment

cholesterol medication

Diet included iron-rich foods such as meat, eggs, iron fortified cereal, or beans Yes No Comment

Does child go to school Yes No Comment

Concerns about child doing well in school No Yes Comment

Does child do simple chores around house Yes No Comment

Does child get along with his/her friends Yes No Comment

Does child eat breakfast everyday Yes No Comment

Does child have at least 3 servings of low fat milk, cheese, or yogurt per day Yes No Comment

Do you limit junk food and fast food Yes No Comment

Concerns about child's weight No Yes Concerns

Primary water source contain fluoride Yes No Comment

Always uses safety/booster seat in back seat of car or any vehicle Yes No Comment

Knows street safety such as looking both ways and knows to never cross without a grown up Yes No Comment

Wears helmet/protective gear when biking, skating, skiing, or snowboarding Yes Sometimes No

Does child know how to swim and knows to only swims when when an adult is watching Yes No Comment

Do you put sunscreen on child before he/she goes outside Yes No Comment

Does anyone smoke around child No Yes Comment

**Cardiac Risk: Has your child ever had:**

Fainting during or after exercise, emotion or startle? No Yes

Extreme shortness of breath with exercise? No Yes

Discomfort, pain or pressure in chest during exercise? No Yes