Patient Name_____

DOB_____

Risk Assessment 7 Year

Is doing well in school	Yes	No	Comments
Participates in after-school activity	Yes	No	Comments
Gets along with family	Yes	No	Comments
Does chores when asked	Yes	No	Comments
Concerns about how child hears	No	Yes	Comment
Concerns about how child speaks	No	Yes	Comment
Concerns about how child sees	No	Yes	Concerns
Does your child squint	No	Yes	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

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Born in country outside of the United States	No	Yes	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
Diet included iron-rich foods such as meat, eggs, iron fortified cereal, or beans	Yes	No	Comment	
Does child eat strict vegetarian diet?	No	Yes	Comment	
Does your child like school	Yes	No	Comment	
Is child involved with school activities	Yes	No	Comment	
Does child get into fights on playground or elsewhere	No	Yes	Comment	
Do you talk to child about what happens when he/she breaks the rules	Yes	No	Comment	
Do you feel comfortable answering questions about child's changing body	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 foods like candy, soft drinks, salty snacks and fast food	Yes	No	Comment	

Do you eat meals together as a family at least once a week	Yes	No	Comment
Does child eat breakfast every day	Yes	No	Comment
Does child brush teeth twice per day	Yes	No	Comment
Does child see dentist at least twice a year	Yes	No	Comment
Does child know to dial 911 in an emergency	Yes	No	Comment
Taught child that it is not ok for adult to ask to keep secrets from parents	Yes	No	Comment
Taught child that it is not ok for an older child or adult to ask to see his/her privates	Yes	No	Comment
Always uses safety or booster seat in the back seat of car or all vehicles	Yes	No	Comment
Wears helmet/protective gear when biking, skating, skiing, or snowboarding	Yes	Sometimes	No
Do you put sunscreen on child before he/she goes out	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