Health Maintenance Questionnaire 4-6 YEARS

LINCOLN PEDIATRIC GROUP

PATIENT NAME:

PARENTS:

Today's Date:
Birth Date:
Age today: Grade:
School:

REASON FOR THIS CHECK UP: ☐Kindergarten ☐Headstart ☐Preschool ☐Routine check-up ☐Other:

PARENTS' CONCERNS

List concerns you have: 1.
2.
3.
4.
5.

Please check any body areas that concern you:

☐Head	☐Heart	☐Bones	☐Hormones
☐Eyes	☐Lungs	☐Joints	☐Blood
☐Ears	☐Intestines	☐Muscles	☐Glands
☐Nose	☐Kidneys	☐Brain	☐Immunity
☐Mouth	☐Genitals	☐Nerves	
☐Throat	☐Skin	☐Mental Health	

Answer the questions below by checking YES or NO. Explain "YES" answers in the space below.

HISTORY	Yes	No
Does your child have a recurrent medical or psychological problem?	☐	☐
List medications taken routinely: ☐none	☐	☐
Has s/he ever had: a serious illness or stayed overnight in a hospital?	☐	☐
an operation?	☐	☐
Does s/he need to stop play and rest more than other kids his/her age?	☐	☐
Has s/he seen a doctor outside of this clinic for any reason?	☐	☐
Does your child have allergies: ☐hay fever ☐asthma ☐hives ☐foods ☐medicine:	☐	☐
Are there any smokers in your child's home or daycare? ☐outside ☐other room	☐	☐
Is there a family history of: ☐diabetes ☐high cholesterol ☐heart disease ☐obesity ☐sudden cardiac death	☐	☐
How many servings a day does your child eat: Juice: Pop: Fruit: Veg: Meat: Milk: Milk products:		
Where does your child get fluoride for their dental health? ☐city water ☐not sure ☐fluoride rinse / recs from dentist ☐natural fluoride in water source ☐fluoride vitamin ☐no known fluoride		
Has it been more than 1 year since your child's last dental check-up?	☐	☐
Do you have concerns about his/her vision or hearing?	☐	☐

- Avoid 2nd hand smoke.
- Dental check up.

Explain questions answered with "yes." Give approximate dates.
1.
2.
3.
4.

PHYSICAL EXAM

Ht____ Wt____ VS:_____

Head	Nose	Lungs	Back
Eyes/Red reflexes	Mouth	Heart	Hips
Ears	Throat	Femoral pulses	Extremities
	Neck	Abdomen	Skin
	Chest	Genitalia	Neurologic

Vision / Hearing

☐With glasses
Nr: L ___/____ R___/____
Far: L___/____ R___/____

500 1000 2000 4000
L
R

LAB

Hgb
UA
Lead
Cholesterol
PPD placed

IMMUNIZATIONS

☐Given at Health Department
Shots up to date? ☐Yes ☐No
Any previous side effects? ☐Yes ☐No
If yes, what?

ASSESSMENT

PLAN

PLEASE COMPLETE OTHER SIDE OF FORM

Patient Name: **Birth Date:**

Child Guidance: age 4 to 6

Who does your child live with?
What activities is s/he involved in?
What does s/he like to do for fun?
Note if there are any specific behavior problems:

BEHAVIOR and DEVELOPMENT	Yes	No
Please have your child write his or her name in the space to the right.		
Is your child able to sit and work at a project for about 20 minutes?	☐	☐
Can s/he talk in good sentences with fairly clear speech?	☐	☐
Does s/he watch less than 2 hours of TV, videos, computer or video games each day?	☐	☐
Does your child help with simple chores around the house?	☐	☐
Do you **compliment** his/her good behavior more than you **correct** bad behavior?	☐	☐
Has your child learned your address and phone number?	☐	☐

CHILD'S SIGNATURE:

SAFETY	Yes	No
Does s/he know what to do in an emergency? (call 911)	☐	☐
Have you discussed "stranger safety" and "inappropriate touching" with your child?	☐	☐
Is your child going to learn how to swim?	☐	☐
Is the water temperature in your house less than 120 degrees?	☐	☐
Do you have smoke detectors and a fire escape plan?	☐	☐
Are any guns in your home locked up with bullets stored separately? ☐No guns in home	☐	☐
Do you have the Poison Control center's number handy?	☐	☐
Does s/he wear a helmet when riding a bike?	☐	☐
Does your child always ride in the back seat of your vehicle?	☐	☐
Which of the following restraint systems does your child use in your vehicle? ☐Convertible car seat ☐Booster seat with built-in straps ☐Safety lap/shoulder belt alone ☐Built-in safety seat ☐Booster seat with lap/shoulder belt ☐Other		
NOTE: Nebraska law requires a safety seat until age 6. Optimal safety recommendations: Children whose weight or height is above the forward-facing limit for their car safety seat should us a Belt-Positioning Booster Seat until the vehicle seat belt fits properly, typically when they have reached 4 feet 9 inches in height and are between 8-12 yrs old. Please review the questions in the column to the right. ➔		

Is your 6 year old (or older child) ready to ride safely without a booster seat?

If you answer "NO" to these questions, your child needs a booster seat, regardless of age:

1. Do they sit all the way back against the auto seat?
2. Do their knees bend comfortably at the edge of the auto seat?
3. Does the belt cross the shoulder between the neck and arm?
4. Is the lap belt as low as possible, touching the thighs?
5. Can they stay seated like this for the whole trip?

TUBERCULOSIS (TB) RISK	Yes	No
Has your child been around anyone with contagious TB or a positive PPD test?	☐	☐
Has your child had contact with people from Asia, Middle East, Africa or Latin America?	☐	☐
Is anyone living in your house infected with HIV?	☐	☐
Has your child been exposed to any of the following people: homeless, nursing home residents, institutionalized people, jail / prison inmates, users of illicit drugs, migrant farm workers.	☐	☐
Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or is immunosuppressed?	☐	☐

TB Risk: High
Low

LEAD RISK	Yes	No
Does your child live in or visit a house built before 1978?	☐	☐
Is there a sibling or playmate with lead poisoning?	☐	☐
Does your child live with someone involved in the following: furniture refinishing or making stained glass or pottery, storage of batteries, using indoor gun firing ranges, automotive repair, construction of bridges, tunnels or elevated highways	☐	☐
Does your child live near: an active smelter, battery recycling plant, mine tailing pile, other industry likely to release lead.	☐	☐
Does your child have an unexplained developmental delay, hearing problem, irritability, severe attention deficit, violent tantrums or unexplained anemia?	☐	☐

Lead Risk: High
Low

Who answered the above questions? *Thank you for helping us help you and your child!!*