Health Maintenance Questionnaire 3 YEARS

LINCOLN PEDIATRIC GROUP

Today's Date:

PATIENT NAME: Birth Date:

PARENTS: Age Today:

REASON FOR THIS CHECK UP: ☐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.
- Routine dental check-ups .

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
Lead
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 3

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
Is your child completely toilet trained?	☐	☐
Does s/he sleep well?	☐	☐
Can your child put his/her clothes on?	☐	☐
Can s/he speak in 3 to 4 word sentences with clear speech?	☐	☐
Can s/he copy a straight line after watching you draw it?	☐	☐
Can your child pedal a tricycle?	☐	☐
Does s/he usually watch less than 2 hours of TV, videos and computer games each day?	☐	☐
Do you **compliment** his/her good behavior more than you **correct** bad behavior?	☐	☐

SAFETY	Yes	No
Have you discussed "stranger safety" and "inappropriate touching" with your child?	☐	☐
Is the water temperature in your house less than 120 degrees?	☐	☐
Do you have smoke detectors and a fire escape plan?	☐	☐
Are guns in your home locked up with bullets stored separately? ☐No guns in our home	☐	☐
Do you have the Poison Control Center's number handy?	☐	☐
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, regardless of weight.
Optimal safety recommendations: 2yrs and older (or younger than 2 but have outgrown the rear-facing weight or height limit for their seat) should use a Forward-Facing Car Seat with a harness for as long as possible, up to the highest weight or height allowed by the seat's manufacturer. Read your safety seat instructions for weight limits and your vehicle's owner's manual regarding other specific instructions.

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 an immunosuppressive condition?	☐	☐

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!!*