Health Maintenance Questionnaire

3 YEARS

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:		
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____ HC____ VS:_____

EXAM:

Vision / Hearing

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

500 1000 2000 4000
L
R

Lab/Immunizations

ASSESSMENT

PLAN

PLEASE COMPLETE OTHER SIDE OF FORM 11/18

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 ☐Forward facing car seat (built-in straps) ☐Lap/shoulder seat belt alone
☐Built-in safety seat ☐Lap/shoulder seat belt positioning booster seat ☐Other:

2019 Nebraska Car Seat law:

1. Kids ride rear-facing at least until they turn 2. **It is safest to stay rear-facing for as long as possible after age 2, until they reach the upper weight or height limit allowed by the car seat's manufacturer.**
2. Kids under age 8 must ride in a child safety seat, regardless of weight.
   NOTE: Once forward facing, use a car seat with a built-in harness for as long as your child fits in it. Then switch to a belt positioning booster seat.
3. Kids under age 8 must ride in the back seat, as long as there is a back seat with a seatbelt which is not already occupied by other children under age 8.
5. The above applies to childcare providers transporting children.

Violation carries a $25 fine plus court costs and 1 point is taken from the driving record.

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!!*