Health Maintenance Questionnaire 7-10 YEARS

LINCOLN PEDIATRIC GROUP

Today's Date:

PATIENT NAME: Birth Date:

Age today: Grade:

PARENTS: School:

REASON FOR THIS CHECK UP: ☐School ☐Sports ☐Camp ☐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 your child ever been told not to participate in a sport?	☐	☐
Has s/he ever had one of these or other serious injuries? ☐fracture ☐dislocation ☐sprain ☐knee injury ☐knocked out ☐memory loss	☐	☐
Has s/he ever been dizzy or blacked out during or after exercise?	☐	☐
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?	☐	☐
Has s/he seen a doctor outside of this clinic for any reason?	☐	☐
Do you or your child have questions about pubertal development?	☐	☐

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

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

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
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 7 to 10

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 learning or behavior problems:
What kind of grades does your child get? ☐Excellent ☐Good ☐Fair ☐Poor ☐Failing

BEHAVIOR and DEVELOPMENT	Yes	No
Does your child enjoy reading for pleasure?	☐	☐
Does s/he take good care of his/her belongings?	☐	☐
Does s/he show concern about rules and fairness?	☐	☐
Does your child make and keep friends easily?	☐	☐
Does s/he watch less than 2 hours of TV, videos, computer or video games each day?	☐	☐
Does your child have assigned chores to do around the house?	☐	☐
Do you **compliment** his/her good behavior more than you **correct** bad behavior?	☐	☐
Is your child given adequate privacy?	☐	☐
Do you thing s/he appears to be HAPPY more often than SAD?	☐	☐
Do you think s/he communicates openly with you?	☐	☐
Do you feel your child has positive adult role models?	☐	☐

SAFETY	Yes	No
Have you discussed "stranger safety" and "inappropriate touching" with your child?	☐	☐
Is your child learning how to swim?	☐	☐
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	☐	☐
Does s/he wear a helmet when riding a bike?	☐	☐
Does your child always ride in the back seat of your vehicle?	☐	☐
Does s/he always wear a seat belt?	☐	☐

NOTE: Nebraska law requires a car 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. ➔
When old enough and large enough to use the vehicle seat belt alone, they should always use Lap and Shoulder Seat Belts for optimal protection. Children under 13 yrs old should be restrained in the rear seat.

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?	☐	☐

Is your 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?

TB Risk: High
Low

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