



Health Maintenance Questionnaire

7-8 YEARS

PATIENT NAME: _____

Today's Date: _____

Birth Date: _____

PARENTS: _____

Age today: _____

Grade: _____

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:

- | | | | |
|---------------------------------|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Heart | <input type="checkbox"/> Bones | <input type="checkbox"/> Hormones |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Lungs | <input type="checkbox"/> Joints | <input type="checkbox"/> Blood |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Intestines | <input type="checkbox"/> Muscles | <input type="checkbox"/> Glands |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Brain | <input type="checkbox"/> Immunity |
| <input type="checkbox"/> Mouth | <input type="checkbox"/> Genitals | <input type="checkbox"/> Nerves | |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Skin | <input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>
List medications taken routinely: <input type="checkbox"/> none		
Has s/he ever had: a serious illness or stayed overnight in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
an operation?	<input type="checkbox"/>	<input type="checkbox"/>
Has s/he seen a doctor outside of this clinic for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
Does s/he need to stop play and rest more than other kids his/her age?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been told not to participate in a sport?	<input type="checkbox"/>	<input type="checkbox"/>
Has s/he ever had one of these or other serious injuries? <input type="checkbox"/> fracture <input type="checkbox"/> dislocation <input type="checkbox"/> sprain <input type="checkbox"/> knee injury <input type="checkbox"/> knocked out <input type="checkbox"/> memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Has s/he ever been dizzy or blacked out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have allergies: <input type="checkbox"/> hay fever <input type="checkbox"/> asthma <input type="checkbox"/> hives <input type="checkbox"/> foods <input type="checkbox"/> medicine:	<input type="checkbox"/>	<input type="checkbox"/>
Are there any smokers in your child's home or daycare? <input type="checkbox"/> outside <input type="checkbox"/> other room	<input type="checkbox"/>	<input type="checkbox"/>
Is there a family history of: <input type="checkbox"/> diabetes <input type="checkbox"/> high cholesterol <input type="checkbox"/> heart disease <input type="checkbox"/> obesity <input type="checkbox"/> sudden cardiac death	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have concerns about your child's vision or hearing?		
Do you or your child have questions about pubertal development?	<input type="checkbox"/>	<input type="checkbox"/>

• Avoid 2nd hand smoke.

• Dental check up.

Explain questions answered with "yes." Give approximate dates.

1. _____
2. _____
3. _____

<p>PHYSICAL EXAM</p> <p>Ht _____ Wt _____ HC _____ VS: _____</p> <p>EXAM: _____</p>		<p>Vision / Hearing</p> <p><input type="checkbox"/> With glasses</p> <p>Nr: L _____ R _____</p> <p>Far: L _____ R _____</p> <p>500 1000 2000 4000</p> <p>L _____</p> <p>R _____</p>	<p>Lab/Immunizations</p>
<p>ASSESSMENT</p>		<p>PLAN</p>	

PLEASE COMPLETE OTHER SIDE OF FORM 11/18

Patient Name:

Birth Date:

Child Guidance: age 7 to 8

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

Table with 2 columns: Question, Yes, No. Rows include: 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 think 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

Table with 2 columns: Question, Yes, No. Rows include: 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?

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 Safety Seat Law:

- 1. Kids under age 8 must ride in a child safety seat, regardless of weight. NOTE: Use a car seat with a built-in harness for as long as your child fits in it, based on the upper weight or height limit allowed by the car seat's manufacturer. Then move to and remain in a belt-positioning booster seat until at least age 8, and thereafter until the vehicle's seat belt fits properly. A seat belt alone typically fits when a kid reaches 4 feet 9 inches tall and is 8-12 years old. (See questions to the right).
2. 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. For safety, it is recommended that all kids under age 13 ride in the back seat.
3. Kids age 8-18 must ride secured in a seat belt or child safety seat (booster seat).
4. The above applies to childcare providers transporting children.
5. Kids under age 18 cannot ride in cargo areas. Violation carries a \$25 fine plus court costs and 1 point is taken from the driving record.

Is your 8 year old (or older child) ready to ride safely without a booster seat and use JUST a seat belt?

- Yes No
 Do they sit all the way back against the auto seat?
 Do their knees bend comfortably at the edge of the auto seat?
 Does the belt cross the shoulder between the neck and arm?
 Is the lap belt as low as possible, touching the thighs?
 Can they stay seated like this for the whole trip?

If your answers are "NO," your child needs a booster seat, regardless of age.

TUBERCULOSIS (TB) RISK

Yes No

Table with 2 columns: Question, Yes, No. Rows include: 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

Who answered the above questions?

Thank you for helping us help you and your child!!

11/18