



# Health Maintenance Questionnaire

**4 to 6 YEARS OLD**

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE TODAY \_\_\_\_ GRADE \_\_\_\_

PARENTS \_\_\_\_\_ SCHOOL \_\_\_\_\_ TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

REASON FOR THIS CHECK UP: Kindergarten Headstart Pre-school Routine check-up Other:

## PARENTS' CONCERNS

Parents, what concerns do you have about your child? →

Please circle 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	PHYSICIAN'S COMMENTS
Does your child have a recurrent medical or psychological problem?			<input type="checkbox"/> Discussed risks of 2 <sup>nd</sup> hand smoke.  <input type="checkbox"/> Prescribed fluoride vitamins. <input type="checkbox"/> Recommended dental check up.
List medications taken routinely: <input type="checkbox"/> 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 need any immunizations as far as you know?			
Does your child have allergies: (circle) hay fever, asthma, hives, foods, medicine _____			
Are there any smokers in your child's home or daycare? <input type="checkbox"/> outside <input type="checkbox"/> other room			
Are there any illnesses that run in your family?			
Has a close relative died before age 55 due to heart or cholesterol problems?			
How many servings a day does your child eat: Juice ____ Pop ____ Fruit ____ Veg ____ Meat ____ Milk ____ Milk products ____			
Does your child usually drink water that is NOT fluoridated? <input type="checkbox"/> Don't know			
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?			

**PLEASE TURN THE PAGE OVER AND ANSWER MORE QUESTIONS!!**

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

ASSESSMENT
1. See Physical Exam Summary and other side of this form for more information.
2. _____
3. _____
4. _____
5. _____
6. _____

PLAN
1. <input type="checkbox"/> Anticipatory Handouts given.
2. _____
3. _____
4. _____
5. _____
6. _____

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ 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	PHYSICIAN'S COMMENTS	
Please have your child write his or her name in the space to the right.				<u>CHILD'S SIGNATURE:</u>
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 <b>compliment</b> his/her good behavior more than you <b>correct</b> bad behavior?				
Has your child learned your address and phone number?				
<b>SAFETY</b>				
	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? <input type="checkbox"/> No guns in our home			<p><b>Is your 6 year old (or older child) ready to ride safely without a booster seat?</b>                      If you answer "NO" to these questions, your child needs a booster seat, regardless of age:</p> <ol style="list-style-type: none"> <li>Do they sit all the way back against the auto seat?</li> <li>Do their knees bend comfortably at the edge of the auto seat?</li> <li>Does the belt cross the shoulder between the neck and arm?</li> <li>Is the lap belt as low as possible, touching the thighs?</li> <li>Can they stay seated like this for the whole trip?</li> </ol>	
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? <input type="checkbox"/> Convertible car seat <input type="checkbox"/> Booster seat with built-in straps <input type="checkbox"/> Safety lap/shoulder belt alone <input type="checkbox"/> Built-in safety seat <input type="checkbox"/> Booster seat with lap/shoulder belt <input type="checkbox"/> Other				
NOTE: Nebraska law requires a safety seat until age 6 (As of July 2002). Optimal safety requires a convertible car seat or a booster seat with built-in straps up to 40 pounds and a booster seat used with the vehicle's lap and shoulder belt between 40 and 80 pounds. Read your safety seat instructions for weight limits and your vehicle's owner's manual regarding the need for a locking clip, etc. Please review the questions in the column to the right. →				
<b>TUBERCULOSIS (TB) RISK</b>				
	Yes	No		
Has your child been around anyone with contagious TB or a positive PPD test?				TB Risk: <input type="checkbox"/> High <input type="checkbox"/> Low
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?				
<b>LEAD RISK</b>				
	Yes	No	Lead Risk: <input type="checkbox"/> High <input type="checkbox"/> Low	
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?				

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

**Please put this paper in the box hanging outside the door so that we know you are finished!**