



# Health Maintenance Questionnaire

**1 to 10 YEARS OLD**

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

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

REASON FOR THIS CHECK UP:  School  Sports  Camp  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?		
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 your child ever been told not to participate in a sport?		
Has s/he ever had one of these or other serious injuries? (circle) 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 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?		
Do you or your child have questions about pubertal development?		

Discussed risks of 2<sup>nd</sup> hand smoke.

Prescribed fluoride vitamins.

Recommended dental check up.

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

Explain questions answered with "yes." \_\_\_\_\_

Give approximate dates. \_\_\_\_\_

## ASSESSMENT

- See Physical Exam Summary and other side of this form for more information.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## PLAN

- Anticipatory Handouts given.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ 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	<b>PHYSICIAN'S COMMENTS</b>  <p style="text-align: center;"><b>Is your child ready to ride safely without a booster seat?</b></p> <p>If you answer "NO" to these questions, your child needs a booster seat, regardless of age:</p> <ol style="list-style-type: none"> <li>1. Do they sit all the way back against the auto seat?</li> <li>2. Do their knees bend comfortably at the edge of the auto seat?</li> <li>3. Does the belt cross the shoulder between the neck and arm?</li> <li>4. Is the lap belt as low as possible, touching the thighs?</li> <li>5. Can they stay seated like this for the whole trip?</li> </ol> <p>TB Risk: <input type="checkbox"/>High <input type="checkbox"/>Low</p>
Does your child enjoy reading for pleasure?	<input type="checkbox"/>	<input type="checkbox"/>	
Does s/he take good care of his/her belongings?	<input type="checkbox"/>	<input type="checkbox"/>	
Does s/he show concern about rules and fairness?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child make and keep friends easily?	<input type="checkbox"/>	<input type="checkbox"/>	
Does s/he watch less than 2 hours of TV, videos, computer or video games each day?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child have assigned chores to do around the house?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you <b>compliment</b> his/her good behavior more than you <b>correct</b> bad behavior?	<input type="checkbox"/>	<input type="checkbox"/>	
Is your child given adequate privacy?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you think s/he appears to be HAPPY more often than SAD?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you think s/he communicates openly with you?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you feel your child has positive adult role models?	<input type="checkbox"/>	<input type="checkbox"/>	
SAFETY	Yes	No	
Have you discussed "stranger safety" and "inappropriate touching" with your child?	<input type="checkbox"/>	<input type="checkbox"/>	
Is your child learning how to swim?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have smoke detectors and a fire escape plan?	<input type="checkbox"/>	<input type="checkbox"/>	
Are any guns in your home locked up with bullets stored separately? <input type="checkbox"/> No guns in our home	<input type="checkbox"/>	<input type="checkbox"/>	
Does s/he wear a helmet when riding a bike?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child always ride in the back seat of your vehicle?	<input type="checkbox"/>	<input type="checkbox"/>	
Does s/he always wear a seat belt?	<input type="checkbox"/>	<input type="checkbox"/>	
NOTE: The law requires a safety seat until age 6, regardless of weight. Optimal safety requires a booster seat used with the vehicle's lap and shoulder belt between 40 and 80 pounds. Your child is safe to ride without a booster seat when the knees can bend over the edge of the seat cushion, the shoulder strap is across the shoulder, the lap belt is over the upper thighs and the child is mature enough to maintain proper position throughout the ride. Please review the questions to the right →			
TUBERCULOSIS (TB) RISK	Yes	No	
Has your child been around anyone with contagious TB or a positive PPD test?	<input type="checkbox"/>	<input type="checkbox"/>	
Has your child had contact with people from Asia, Middle East, Africa or Latin America?	<input type="checkbox"/>	<input type="checkbox"/>	
Is anyone living in your house infected with HIV?	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?	<input type="checkbox"/>	<input type="checkbox"/>	

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!**