

MR #

DOB



NAME

Bassett Healthcare Network
Cooperstown, New York 13326-1394

DATE

PEDIATRIC HEALTH MAINTENANCE RECORD

H-4262 7/98;1/99;10/99;4/03 (d:\forms\hosp.doc)

Health Center: _____

Health Maintenance Visits—6, 7 Years Old

We are here to help you take care of your health. Please answer the following questions so we can check on how you are doing. Parents: Please help your child complete this form. You may skip any questions you do not wish to answer.

CONCERNS

1. What concerns or questions do you have about your health? _____

INTERVAL HISTORY

- 2. Have you had any serious sicknesses or accidents since your last checkup? YES NO
Describe: _____
- 3. Have you had any immunizations (shots) besides the ones we gave you here? YES NO
Which ones and dates: _____
- 4. Do you have any allergies? YES NO
What are they? _____
- 5. Have you missed more than 10 days of school this year because of sickness? YES NO
Did you miss more than 10 days of school last year because of illness? YES NO
- 6. Are there any medications that you take every day? YES NO
If so, what medicine? _____
- 7. Have you had chickenpox? NO YES

DEVELOPMENT

- 8. What grade are you in? _____
- 9. Are you doing well in school? NO YES
If not, what problem are you having? _____

- 10. Is school too hard for you? YES NO
- 11. Do you have trouble paying attention? YES NO
- 12. Do you have trouble following the rules? YES NO
- 13. What do you do for fun in your free time? _____

- 14. Are you happy with your friends? NO YES
- 15. Do your parents give you punishments if you do something wrong? NO YES
How are you punished? _____

- 16. Do you have jobs or chores at home? NO YES
- 17. Have you learned where babies come from? NO YES
- 18. Are you satisfied with your height and weight? NO YES

(over)

HEALTH HABITS

19. List everything you have had to eat or drink so far today:

- | | | |
|--|------------------------------|------------------------------|
| 20. Does your family eat a meal together at least once a day? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 21. Do you usually eat breakfast? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 22. Do you usually drink milk? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 23. Do you exercise almost every day? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 24. Do you watch TV or play video games more than 2 hours every day? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 25. Do you have a regular bedtime? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| What is it? _____ | | |
| 26. Have you had a dental checkup? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 27. Are you taking fluoride, or is there fluoride in your water? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 28. Do you brush your teeth at least twice a day? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 29. Does anyone smoke cigarettes in your home? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

SAFETY

- | | | |
|--|------------------------------|------------------------------|
| 30. Have you taken swimming lessons? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 31. Can you swim in deep water without a float? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 32. Do you always wear a seat belt in the car? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 33. Do you wear your bike helmet when you ride your bike? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| Where do you ride your bike? _____ | | |
| 34. Are there guns in your house? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 35. Do you live or work on a farm? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 36. Do you ride the lawn mower, tractor, a 4-wheeler? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 37. Who takes care of you when Mom and Dad aren't home? _____ | | |
| 38. Do you know which numbers to call in an emergency (fire, ambulance, police)? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| 39. Who would you tell if someone was trying to touch your private parts? _____ | | |
| 40. Do you know what AIDS means? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |

FAMILY

- | | | |
|---|------------------------------|-----------------------------|
| 41. Is your family having any serious problems that worry you?
If so, what is the problem? _____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 42. What does your family like to do together? _____ | | |
| 43. Do any of your relatives have a serious illness?
If so, who is it? _____
What is the illness? _____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 44. Do either of your parents have a cholesterol level over 240? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 45. Have any of your parents or grandparents had any of the following problems
when they were younger than age 55? | | |
| Heart attack | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Stroke | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Blood clots | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Heart bypass surgery | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 46. Do any of your friends or relatives have tuberculosis? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

REVIEW OF SYSTEMS

Are you having any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> feeling tired | <input type="checkbox"/> frequent sore throats | <input type="checkbox"/> trouble going to the bathroom |
| <input type="checkbox"/> skin trouble | <input type="checkbox"/> swollen glands | <input type="checkbox"/> bedwetting |
| <input type="checkbox"/> headaches | <input type="checkbox"/> breast problems | <input type="checkbox"/> soiling your underwear or constipation |
| <input type="checkbox"/> dizziness or fainting | <input type="checkbox"/> cough, chest pain, or breathing problems | <input type="checkbox"/> problem with your private parts |
| <input type="checkbox"/> eye or vision problem | <input type="checkbox"/> inability to exercise | <input type="checkbox"/> pains in bones or muscles |
| <input type="checkbox"/> ear or hearing problem | <input type="checkbox"/> heart problems | <input type="checkbox"/> seizures or convulsions |
| <input type="checkbox"/> runny or stuffy nose, nosebleeds | <input type="checkbox"/> stomach aches, nausea, vomiting | <input type="checkbox"/> speech problem |
| <input type="checkbox"/> tooth problems | <input type="checkbox"/> appetite or eating problem | <input type="checkbox"/> mood problem |
| <input type="checkbox"/> other _____ | | |