

MR #

DOB



\* 6 6 1 2 \*

NAME

BASSETT HEALTHCARE NETWORK  
Cooperstown, NY 13326-1394

DATE

### PEDIATRIC HEALTH MAINTENANCE RECORD

H-6612 7/03 (d:\forms\hosp.doc)

CLINIC: \_\_\_\_\_

Health Maintenance Visits—5 Years Old

#### CONCERNS

1. What concerns or questions do you have about your child's health? \_\_\_\_\_  
\_\_\_\_\_

#### INTERVAL HISTORY

- 2. Has your child had any serious sicknesses or accidents since your last checkup? YES  NO   
Describe: \_\_\_\_\_
- 3. Have any immunizations (shots) been given besides the ones we gave here? YES  NO   
Which ones and dates: \_\_\_\_\_
- 4. Does your child have any allergies? YES  NO   
What are they? \_\_\_\_\_
- 5. Are there any medications that your child takes every day? YES  NO   
If so, what medicine? \_\_\_\_\_

#### DEVELOPMENT

How well does your child do the following?

	Not well	Pretty well	Very well
6. Run, jump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Use a pencil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Dress self except shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Understand, remember, and follow instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Sing songs or recite nursery rhymes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Tell a story	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Find the right words for things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Remember belongings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Remember familiar places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Look at books alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Show interest in how things work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Try to play sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Use words instead of being physical when angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Take turns and share	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Follow rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Separate from parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(over)

## HEALTH HABITS

22. List everything your child has had to eat or drink so far today:

\_\_\_\_\_

- |   |                              |                              |
|---|------------------------------|------------------------------|
| 23. Does your family eat a meal together at least once a day?                 | NO <input type="checkbox"/>  | YES <input type="checkbox"/> |
| 24. Does your child usually drink milk?                                       | NO <input type="checkbox"/>  | YES <input type="checkbox"/> |
| 25. Is your child physically active?  | NO <input type="checkbox"/>  | YES <input type="checkbox"/> |
| 26. Does your child watch TV or play video games more than 2 hours every day? | YES <input type="checkbox"/> | NO <input type="checkbox"/>  |
| 27. Does your child have a regular bedtime?<br>What is it? _____              | NO <input type="checkbox"/>  | YES <input type="checkbox"/> |
| 28. Has your child had a dental checkup?                                      | NO <input type="checkbox"/>  | YES <input type="checkbox"/> |
| 29. Is your child taking fluoride, or is there fluoride in your water?        | NO <input type="checkbox"/>  | YES <input type="checkbox"/> |
| 30. Does your child brush his/her teeth at least twice a day?                 | NO <input type="checkbox"/>  | YES <input type="checkbox"/> |
| 31. Does anyone smoke cigarettes in your home?                                | YES <input type="checkbox"/> | NO <input type="checkbox"/>  |

## SAFETY

- |   |                              |                              |
|---|------------------------------|------------------------------|
| 32. Does your child wear a seat belt?   | NO <input type="checkbox"/>  | YES <input type="checkbox"/> |
| 33. Does your child wear a bike helmet?   | NO <input type="checkbox"/>  | YES <input type="checkbox"/> |
| 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. Does your child ride a lawn mower, tractor, 4-wheeler, or snowmobile?                 | YES <input type="checkbox"/> | NO <input type="checkbox"/>  |
| 37. Does your child know which numbers to call in an emergency (fire, ambulance, police)? | NO <input type="checkbox"/>  | YES <input type="checkbox"/> |
| 38. Does your child know who to tell if someone was trying to touch their private parts?  | NO <input type="checkbox"/>  | YES <input type="checkbox"/> |

## FAMILY

39. Who will be caring for your child after school? \_\_\_\_\_
40. Is your family having any serious problems? YES  NO   
If so, what is the problem? \_\_\_\_\_
41. What does your family like to do together? \_\_\_\_\_
42. Do any of your relatives have a serious illness? YES  NO   
If so, who is it? \_\_\_\_\_  
What is the illness? \_\_\_\_\_
43. Do either of the child's parents have a cholesterol level over 240? YES  NO
44. Have any of the child's 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"/> |
45. Do any of your friends or relatives have tuberculosis? YES  NO

## REVIEW OF SYSTEMS

Is your child 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 underwear or constipation |
| <input type="checkbox"/> dizziness or fainting            | <input type="checkbox"/> cough, chest pain, or breathing problems | <input type="checkbox"/> problem with 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 _____                      |   |  |