MR # DOB

NAME

DATE

* 4 2 6 2 *

Bassett Healthcare Network
Cooperstown, New York 13326-1394

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

SAFETY

30. Have you taken swimming lessons?	NO ☐	YES ☐
31. Can you swim in deep water without a float?	NO ☐	YES ☐
32. Do you always wear a seat belt in the car?	NO ☐	YES ☐
33. Do you wear your bike helmet when you ride your bike? Where do you ride your bike? _____	NO ☐	YES ☐
34. Are there guns in your house?	YES ☐	NO ☐
35. Do you live or work on a farm?	YES ☐	NO ☐
36. Do you ride the lawn mower, tractor, a 4-wheeler?	YES ☐	NO ☐
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 ☐	YES ☐
39. Who would you tell if someone was trying to touch your private parts? _____		
40. Do you know what AIDS means?	NO ☐	YES ☐

FAMILY

41. Is your family having any serious problems that worry you? If so, what is the problem? _____	YES ☐	NO ☐
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 ☐	NO ☐
44. Do either of your parents have a cholesterol level over 240?	YES ☐	NO ☐
45. Have any of your parents or grandparents had any of the following problems when they were younger than age 55?		
Heart attack	YES ☐	NO ☐
Stroke	YES ☐	NO ☐
Blood clots	YES ☐	NO ☐
Heart bypass surgery	YES ☐	NO ☐
46. Do any of your friends or relatives have tuberculosis?	YES ☐	NO ☐

REVIEW OF SYSTEMS

Are you having any of the following:

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