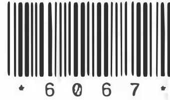
MR # DOB

NAME

DATE



BASSETT HEALTHCARE NETWORK
Cooperstown, New York 13326-1394

PEDIATRIC HEALTH MAINTENANCE RECORD

H 6067 7/98;1/99;10/99;6/03 (d:\forms\hosp\doc)

Health Center: ______________________

Health Maintenance Visits— 8-10 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. Ask your parents for help filling out 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 sickness? YES ☐ NO ☐
6. Are there any medicines that you take every day? YES ☐ NO ☐
   If so, what medicines? ______________________
7. Have you had chickenpox? YES ☐ NO ☐

DEVELOPMENT

8. What grade are you in? ______________
9. Are you doing well in school? NO ☐ YES ☐
   If not, what problems are you having? ______________________
10. Is school work 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 are your activities outside of school? (sports, music, scouts, etc.) ______________
14. Are you happy with your friends? NO ☐ YES ☐
15. Do you have a best friend? NO ☐ YES ☐
16. Do you ever get into fights? YES ☐ NO ☐
17. Do your parents give you punishments when you do something wrong? NO ☐ YES ☐
    What are your punishments? ______________________
18. Do you have jobs or chores at home? NO ☐ YES ☐
19. Are you satisfied with your height and weight? NO ☐ YES ☐
20. Do you have questions about the changes that will happen to your body as you become a teenager? YES ☐ NO ☐
21. Do you have questions about sex? YES ☐ NO ☐
    Who do you ask when you do have questions about sex? ______________
22. What do you like best about yourself? ______________
23. What would you change about yourself or your life if you could? ______________

(over)

HEALTH MAINTENANCE LIST Ped

HEALTH HABITS

24. What have you had to eat and drink so far today? ____________

25. Does your family eat at least one meal a day together? NO ☐ YES ☐
26. Do you usually eat breakfast? NO ☐ YES ☐
27. Do you usually drink milk? NO ☐ YES ☐
28. Do you exercise almost every day? NO ☐ YES ☐
29. Do you spend more than 2 hours a day watching TV or playing video games? YES ☐ NO ☐
30. Do you have a regular bedtime on school nights? NO ☐ YES ☐
    What is it? ____________
31. Do you sleep well? NO ☐ YES ☐
32. Have you been getting dental checkups every 6-12 months? NO ☐ YES ☐
33. Are you taking fluoride? (in tablets or in your water) NO ☐ YES ☐
34. Do you brush your teeth at least twice a day? NO ☐ YES ☐
35. Does anyone in your home smoke cigarettes? YES ☐ NO ☐
36. Have you ever tried cigarettes, alcohol, or drugs? YES ☐ NO ☐

SAFETY

37. Can you swim the length of a pool without touching the bottom? NO ☐ YES ☐
38. Do you always wear a seat belt in the car? NO ☐ YES ☐
39. Do you wear your bike helmet when you ride your bike? NO ☐ YES ☐
40. Do you go skateboarding or rollerblading? YES ☐ NO ☐
    If so, what rules have your parents made? ____________
41. Are there guns in your house? YES ☐ NO ☐
42. Do you shoot a gun? YES ☐ NO ☐
43. Do you live or work on a farm? YES ☐ NO ☐
    If so, what are your jobs? ____________
44. Do you drive or ride a lawn mower, tractor, or 4-wheeler? YES ☐ NO ☐
45. Who takes care of you when Mom and Dad aren't home? ____________
46. Do you know which numbers to call in an emergency (fire, ambulance, police)? NO ☐ YES ☐
47. Who would you tell if someone was trying to touch your private parts? ____________
48. Have you ever been physically or sexually abused? YES ☐ NO ☐
49. Do you know how people get AIDS? NO ☐ YES ☐

FAMILY

50. Is your family having any serious problems that worry you? YES ☐ NO ☐
    If so, what is the problem? ____________
51. What does your family like to do together? ____________
52. Do any of your relatives have a serious illness? YES ☐ NO ☐
    If so, who is it? ____________
    What is the illness? ____________
53. Do either of your parents have a cholesterol level over 240? YES ☐ NO ☐
54. Have 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 ☐
55. 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
- ☐ other ____________
- ☐ 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