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	☐	☐	☐
7. Use a pencil	☐	☐	☐
8. Dress self except shoes	☐	☐	☐
9. Understand, remember and follow instructions	☐	☐	☐
10. Sing songs or recite nursery rhymes	☐	☐	☐
11. Tell a story	☐	☐	☐
12. Find the right words for things	☐	☐	☐
13. Remember belongings	☐	☐	☐
14. Remember familiar places	☐	☐	☐
15. Look at books alone	☐	☐	☐
16. Show interest in how things work	☐	☐	☐
17. Try to play sports	☐	☐	☐
18. Use words instead of being physical when angry	☐	☐	☐
19. Take turns and share	☐	☐	☐
20. Follow rules	☐	☐	☐
21. Separate from parents	☐	☐	☐

(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 ☐	YES ☐
24. Does your child usually drink milk?	NO ☐	YES ☐
25. Is your child physically active?	NO ☐	YES ☐
26. Does your child watch TV or play video games more than 2 hours every day?	YES ☐	NO ☐
27. Does your child have a regular bedtime? What is it? _____	NO ☐	YES ☐
28. Has your child had a dental checkup?	NO ☐	YES ☐
29. Is your child taking fluoride, or is there fluoride in your water?	NO ☐	YES ☐
30. Does your child brush his/her teeth at least twice a day?	NO ☐	YES ☐
31. Does anyone smoke cigarettes in your home?	YES ☐	NO ☐

SAFETY

32. Does your child wear a seat belt?	NO ☐	YES ☐
33. Does your child wear a bike helmet?	NO ☐	YES ☐
34. Are there guns in your house?	YES ☐	NO ☐
35. Do you live or work on a farm?	YES ☐	NO ☐
36. Does your child ride a lawn mower, tractor, 4-wheeler, or snowmobile?	YES ☐	NO ☐
37. Does your child know which numbers to call in an emergency (fire, ambulance, police)?	NO ☐	YES ☐
38. Does your child know who to tell if someone was trying to touch their private parts?	NO ☐	YES ☐

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 ☐	NO ☐
Stroke	YES ☐	NO ☐
Blood clots	YES ☐	NO ☐
Heart bypass surgery	YES ☐	NO ☐

45. Do any of your friends or relatives have tuberculosis? YES ☐ NO ☐

REVIEW OF SYSTEMS

Is your child 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 underwear or constipation
- ☐ problem with private parts
- ☐ pains in bones or muscles
- ☐ seizures or convulsions
- ☐ speech problem
- ☐ mood problem
- ☐ other _____