HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

						Parent /	Guardian			Date	_
Name:					Birthda	ite:			Male/Fen	nale:	
Address:											
Parent/Guardian:											
Child lives with:						-					
Number in household:											1
Physician:	•				Date o	f last exan	nination:				****
Dentist:											
Eye Doctor:							_				4
School:											
MILY HEALTH HISTOR	RY						,			-	
	Aaternal		P = Pate	mal	S	= Sibling	2	NA = N	ot applica	ble	
						-		Code	Comment		
1. Are there any chronic i	illness prob	olems in yo	ur family	such as he	art disease	diabetes.	_				
cancer, convulsions, m							, , , , , ₋				
2. Does any family memb	er have a	vision defe	ct, hearing	g loss or sp	oinal defor	mity? Co	mment? _			· .	
LD/ADOLESCENT HIS	TORY										
ponse Codes: Y = Y	es		$N = N_0$		NA =	Not applic	cable	ı			
1. Birthweight	Were there	any pre-n	atal or del	livery prob	lems with	the child?	_				
2. Did this child walk, tall							_		+		
3. Does this child/adolesco		•									
a. See a health care	provider r	egularly?								•	173
b. Use any medicati	-	-	?				_				
c. Have a history of				or emerge	ncv room	visits?	_				,
d. Have a history of	-		•	_							
e. Have a history of	-						1				
f. Age menarche					7		-		٠.		
		•				-n	-				:
•	•		_		u broosem	s:	-				
h. Have a problem v	_						-				
i. Have any emotion		-					-				
j. Need any special	_	lool or day	care?				-				
k. Have sexuality co							_				
1. Have any chronic	illness or	disabling p	roblems w	vith:							
Headache	Conv	ulsions/		Diabe	etes	Ea	raches	E	ack/spine	/	
Colds/sore throat	Rheu	matic feve	r	Genit	alia	Or	al/dental		_	problems	s
Heart/lung disease	Aller	gies/asthm	a	Diges	stive	Ur	inary/bowe	al C	ther	•	
Colds/sore throat	Rheu Aller	matic feve gies/asthm	a		alia	_ Or			extremity		·
Immunization:	-			ceived (mr		·					
	1st	2nd	3rd	4th	5th	6th			1st	2nd	3rd
DPT (Diphtheria, portusais, tetarum)							MMR (Mea	sles, Muzzps, Rubella)			
Td/DT							HBV (Hepat	itis B)	1,0		
ODV on IDV out											

Height	Weight	7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		. He	b or Hct	
Pulse	Blood Pressu	re		Le		Language of the second of the second
Urinalysis	Sickle Cell			Oti	her	· · · · · · · · · · · · · · · · · · ·
Tuberculosis	Head Circum					
Code Each Item as Follows:	Code		Description of	Findings		:
0 = No significant findings	*					
1 = Significant findings			•. •			<u> </u>
General Appearance			•	· · ·		
Integument						:
Head - Neck			: . :			
EENT		. ** **		•		
Oral - Dental				•		
Thorax					•	·
Breasts	1					* . 1
Cardiovascular			*			
Abdomen						
Musculoskeletal						
Genitourinary						r
Neurological .						•. •
Food intake review. Results: milk/milk products (breastfed/type fruit/vegetables	ecciving Vitamin S	Supplement with iron		on		Tuoride Supplement
☐ Enrolled in WIC ☐ R Food intake review. Results: milk/milk products (breastfed/type	eceiving Vitamin S	Supplement with iron	□ Without in	on		Tuoride Supplement
☐ Enrolled in WIC ☐ R Food intake review. Results: milk/milk products (breastfed/type fruit/vegetables meat, beans, eggs breads, cereals 2. Development:Type of screen	ecceiving Vitamin S of formula)	Supplement with iron	□ Without in	on		Tuoride Supplement
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