COOKEVILLE PEDIATRIC ASSOCIATES, P.C.
6 - 10 YEAR CHECKUP QUESTIONNAIRE

PATIENT:______________________ GUARANTOR:____________________

DOB:__/__/___ DATE: __/__/__

Source of information: (check one)

Mother ___

Father ___

Other (specify)____________________________

Which of the following do you have? (check one)

City water ____ Well water ____ Bottled water ____ Spring water ____

Has the child experienced any of the following?

Hearing loss:	Yes ___	No ___
Evidence of hearing loss:	Yes ___	No ___
Difficulty in speech:	Yes ___	No ___
Eyesight problems:	Yes ___	No ___
Family history of high cholesterol:	Yes ___	No ___
Family history of heart attacks before age 55:	Yes ___	No ___

DIETARY HISTORY:

Milk – type and amount ____________________

Fruit: ____________________

Vegetables ____________________

Meat ____________________

Snacks ____________________

Caloric beverages – type and amount ____________________

EDUCATION LEVEL: ____________________

GOOD SCHOOL PERFORMANCE Yes ___ No ___

DEVELOPMENTAL:

Skips	Yes ___	No ___
Dresses without help	Yes ___	No ___
Appropriate home behavior	Yes ___	No ___
Appropriate school behavior	Yes ___	No ___
Appropriate behavior playing w/friend	Yes ___	No ___
Reading – doing math at grade level	Yes ___	No ___
Pride in achievement	Yes ___	No ___
Talks about what goes on in school	Yes ___	No ___
Completes school work	Yes ___	No ___
Delayed developmental milestones	Yes ___	No ___

FOR GIRLS: No period (check if correct) ____

Normal period Yes ___ No ___

Last menstrual period ____________________

How long do they last? ________ days

First period at age_______ yrs old

Any abnormal periods? Yes ___ No ___

If so, how often? ____________________

If so, how long do they last?____________________

TUBERCULOSIS: (Mandatory questions)

Has the child been in close contact with a person with infectious tuberculosis?
Yes ____ No ____ Unsure ____
Does the child have HIV infection or considered at risk for HIV infection?
Yes ____ No ____ Unsure ____
Is the child foreign born (especially if born in Asia, Africa or Latin America), a refugee, or an immigrant?
Yes ____ No ____ Unsure ____
Is the child in contact with the following individuals? HIV infected, homeless, nursing home residents, institutionalized or incarcerated adolescents or adults, illicit drug users or immigrant farm workers?
Yes ____ No ____ Unsure ____
Does the child have a depressed immune system, either because of disease or treatment of disease?
Yes ____ No ____ Unsure ____
Does the child live in an established "high risk for tuberculosis" community or area?
Yes ____ No ____ Unsure ____

Risk Assessment Questionnaire

Patient's Name ____________________ **DOB** ___/___/___

Assessment Date ___/___/____

Lead (ages 6 – 72 months): Mandatory questions	Yes	No	Unsure
Does the child live in or regularly visit a house/apartment built before 1950? This could include a daycare center, home of a baby sitter, or a relative.)			
Does the child live in or regularly visit a house/apartment built before 1978 with recent or ongoing remodeling?			
Does the child have a sibling or a playmate that has, or did have lead poisoning?			

Lead (ages 6 – 72 months):Optional questions	Yes	No	Unsure
Does child live near or visit with someone who lives near a lead smelter, battery recycling plant or other industry that could release lead or has a hobby which uses lead such as welding, construction, or pottery making?			
Does your child frequently come in contact with an adult who works with lead (construction, welding, pottery, etc.)			
Have you ever been told that your child has low iron?			
Does your child live in or regularly visit a house(or daycare facility) built before 1960?			
Does your family use pottery ware or lead crystal for cooking, eating or drinking?			
Has child been seen eating paint chips, crayons, or soil/dirt?			
Is child given any home or folk remedies that may contain lead (may include moonshine Azarcon, Greta, Paylooah)?			
Does your home's plumbing have lead pipes or copper pipes with lead solder joints?			

Please note: Lead level laboratory tests are mandatory at 12 and 24 months.

Tuberculosis (Initiate @ one- year)	Yes	No	Unsure
Has child been in close contact with a person with infectious tuberculosis?			
Does child have HIV infection or considered at risk for HIV infection?			
Is child foreign born (especially if born in Asia, Africa or Latin America), a refugee, or an immigrant?			
Is child in contact with the following individuals? HIV infected, homeless, nursing home residents, institutionalized or incarcerated adolescents or adults, illicit drug users, or migrant farm workers?			
Does child have a depressed immune system, either because of disease or treatment of disease?			
Does child live in an established "high risk for tuberculosis" community or area?			

Cholesterol (Initiate @ two- years)	Yes	No	Unsure
Does child have risk factors for future coronary disease such as physical inactivity, obesity, or Diabetes Mellitus?			
Is there a family history (parents and grandparents) of coronary or peripheral vascular disease below age 55?			
Is there a family history (parents and grandparents) of elevated blood cholesterol?			

Pediatric Symptom Checklist 17 (PSC-17)

Child's Name: ______________________ Date of Birth: ______________

Filled out by: ______________________ Today's Date: ______________

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child. **Please mark under the heading that best describes your child:**

		Never	Sometimes	Often
◆	Fidgety, unable to sit still	0	1	2
■	Feels sad, unhappy	0	1	2
◆	Daydreams too much	0	1	2
●	Refuses to share	0	1	2
●	Does not understand other people's feelings	0	1	2
■	Feels hopeless	0	1	2
◆	Has trouble concentrating	0	1	2
●	Fights with other children	0	1	2
■	Is down on him or herself	0	1	2
●	Blames others for his or her troubles	0	1	2
■	Seems to have less fun	0	1	2
●	Does not listen to rules	0	1	2
◆	Acts as if driven by a motor	0	1	2
●	Teases others	0	1	2
■	Worries a lot	0	1	2
●	Takes things that do not belong to him or her	0	1	2
◆	Distracted easily	0	1	2

Total ◆ __________ Total ● __________ ◆ + ● + ■ = ___

Total ■ __________

*The tool above is reprinted with permission of Michael Jellinek, MD, & J. Michael Murphy, EdD. This 17-item version was developed by W. Gardner & K. Kelleher.

Bright Futures Parent Handout
5 and 6 Year Visits

Here are some suggestions from Bright Futures experts that may be of value to your family.

ORAL HEALTH

Healthy Teeth

- Help your child brush his teeth twice a day.
  - After breakfast
  - Before bed
- Use a pea-sized amount of toothpaste with fluoride.
- Help your child floss her teeth once a day.
- Your child should visit the dentist at least twice a year.

SCHOOL READINESS

Ready for School

- Take your child to see the school and meet the teacher.
- Read books with your child about starting school.
- Talk to your child about school.
- Make sure your child is in a safe place after school with an adult.
- Talk with your child every day about things he liked, any worries, and if anyone is being mean to him.
- Talk to us about your concerns.

MENTAL HEALTH

Your Child and Family

- Give your child chores to do and expect them to be done.
- Have family routines.
- Hug and praise your child.
- Teach your child what is right and what is wrong.
- Help your child to do things for herself.
- Children learn better from discipline than they do from punishment.
- Help your child deal with anger.
  - Teach your child to walk away when angry or go somewhere else to play.

NUTRITION AND PHYSICAL ACTIVITY

Staying Healthy

- Eat breakfast.
- Buy fat-free milk and low-fat dairy foods, and encourage 3 servings each day.
- Limit candy, soft drinks, and high-fat foods.
- Offer 5 servings of vegetables and fruits at meals and for snacks every day.
- Limit TV time to 2 hours a day.
- Do not have a TV in your child's bedroom.
- Make sure your child is active for 1 hour or more daily.

SAFETY

Safety

- Your child should always ride in the back seat and use a car safety seat or booster seat.
- Teach your child to swim.
- Watch your child around water.
- Use sunscreen when outside.
- Provide a good-fitting helmet and safety gear for biking, skating, in-line skating, skiing, snowboarding, and horseback riding.
- Have a working smoke alarm on each floor of your house and a fire escape plan.
- Install a carbon monoxide detector in a hallway near every sleeping area.
- Never have a gun in the home. If you must have a gun, store it unloaded and locked with the ammunition locked separately from the gun.
- Ask if there are guns in homes where your child plays. If so, make sure they are stored safely.
- Teach your child how to cross the street safely. Children are not ready to cross the street alone until age 10 or older.
- Teach your child about bus safety.
- Teach your child about how to be safe with other adults.
  - No one should ask for a secret to be kept from parents.
  - No one should ask to see private parts.
  - No adult should ask for help with his private parts.

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org

American Academy of Pediatrics

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