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
7 and 8 Year Visits

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

NUTRITION AND PHYSICAL ACTIVITY

Staying Healthy

- Eat together often as a family.
- Start every day with breakfast.
- Buy fat-free milk and low-fat dairy foods, and encourage 3 servings each day.
- Limit soft drinks, juice, candy, chips, and high-fat food.
- Include 5 servings of vegetables and fruits at meals and for snacks daily.
- Limit TV and computer time to 2 hours a day.
- Do not have a TV or computer in your child's bedroom.
- Encourage your child to play actively for at least 1 hour daily.

SAFETY

Safety

- Your child should always ride in the back seat and use a booster seat until the vehicle's lap and shoulder belt fit.
- Teach your child to swim and watch her in the water.
- Use sunscreen when outside.
- Provide a good-fitting helmet and safety gear for biking, skating, in-line skating, skiing, snowboarding, and horseback riding.
- Keep your house and cars smoke free.
- 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.

SAFETY

- Watch your child's computer use.
  - Know who she talks to online.
  - Install a safety filter.
- Know your child's friends and their families.
- Teach your child plans for emergencies such as a fire.
  - Teach your child how and when to dial 911.
- Teach your child 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.

DEVELOPMENT AND MENTAL HEALTH

Your Growing Child

- Give your child chores to do and expect them to be done.
- Hug, praise, and take pride in your child for good behavior and doing well in school.
- Be a good role model.
- Don't hit or allow others to hit.
- Help your child to do things for himself.
- Teach your child to help others.
- Discuss rules and consequences with your child.
- Be aware of puberty and body changes in your child.
- Answer your child's questions simply.
- Talk about what worries your child.

SCHOOL

School

- Attend back-to-school night, parent-teacher events, and as many other school events as possible.
- Talk with your child and child's teacher about bullies.
- Talk to your child's teacher if you think your child might need extra help or tutoring.
- Your child's teacher can help with evaluations for special help, if your child is not doing well.

ORAL HEALTH

Healthy Teeth

- Help your child brush 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.
- Encourage your child to always wear a mouth guard to protect teeth while playing sports.

Poison Help: 1-800-222-1222

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

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families

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