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
9 and 10 Year Visits

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

NUTRITION AND PHYSICAL ACTIVITY

Staying Healthy

- Encourage your child to eat healthy.
- Buy fat-free milk and low-fat dairy foods, and encourage 3 servings each day.
- Include 5 servings of vegetables and fruits at meals and for snacks daily.
- Limit TV and computer time to 2 hours a day.
- Encourage your child to be active for at least 1 hour daily.
- Eat as a family often.

SAFETY

Safety

- The back seat is the safest place to ride in a car until your child is 13 years old.
- Use a booster seat until the vehicle's safety belt fits. The lap belt can be worn low and flat on the upper thighs. The shoulder belt can be worn across the shoulder and the child can bend at the knees while sitting against the vehicle seat back.
- Teach your child to swim and watch her in the water.
- Your child needs sunscreen (SPF 15 or higher) when outside.
- Your child needs a helmet and safety gear for biking, skating, in-line skating, skiing, snowmobiling, and horseback riding.
- Talk to your child about not smoking cigarettes, using drugs, or drinking alcohol.
- Make a plan for situations in which your child does not feel safe.
- Get to know your child's friends and their families.
- Never have a gun in the home. If necessary, store it unloaded and locked with the ammunition locked separately from the gun.

DEVELOPMENT AND MENTAL HEALTH

Your Growing Child

- Be a model for your child by saying you are sorry when you make a mistake.
- Show your child how to use his words when he is angry.
- Teach your child to help others.
- Give your child chores to do and expect them to be done.
- Give your child his own space.
- Still watch your child and your child's friends when they are playing.
- Understand that your child's friends are very important.
- Answer questions about puberty.
- Teach your child the importance of delaying sexual behavior. Encourage your child to ask questions.
- 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 your child's private parts.
  - No adult should ask for help with his private parts.

SCHOOL

School

- Show interest in school activities.
- If you have any concerns, ask your child's teacher for help.
- Praise your child for doing things well at school.
- Set a routine and make a quiet place for doing homework.
- Talk with your child and her teacher about bullying.

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 his 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

American Academy
of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

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