

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

PEDIATRIC QUESTIONNAIRE AGE 15 MONTHS AND OVER

Form Completed By _____

When was your last visit to the Immunizations Clinic? _____

Sports Related Questions (All patients ages 5 and over)

Yes / No Ever had any fractures or major injuries?	Yes / No Have you been diagnosed with mononucleosis?
Yes / No Ever had asthma or wheezing?	Yes / No Do you ever worry about your weight?
Yes / No Have you had trouble breathing recently?	Yes / No Have you recently been evaluated for a skin infection?
Yes / No Ever had a heart murmur?	Yes / No Are you <u>unable</u> to run two laps around the track (1/2 mile)?
Yes / No Ever had a heart abnormality?	Yes / No Do you have 1 of a paired organ (kidneys, testes, ovaries, eyes)?
Yes / No Wear dental bridges or braces?	Yes / No Ever had an injury that required a hospital stay?
Yes / No Ever had a seizure?	Yes / No Ever had an injury that required you to miss 3 days of practice?
Yes / No Ever had a concussion?	Yes / No Ever had chest pain, dizziness, or fainting with exercise?
Yes / No Ever had loss of consciousness?	Yes / No Do you have frequent headaches?

Describe any responses with "yes" above:

Lead Screen (All patients ages 6 and below)

- | | |
|--|---------------------------|
| 1. Does your child spend time in a home or daycare built before 1950 with chipping paint? | YES / NO / UNKNOWN |
| 2. Has your child spent time in a building built before 1978 while it was being renovated? | YES / NO / UNKNOWN |
| 3. Does your child have a sibling or playmate with known lead poisoning? | YES / NO / UNKNOWN |
| 4. Does anyone in the home have a job or hobby which involves lead (e.g. refinishing furniture, loading bullets, soldering, making stained glass windows, etc.)? | YES / NO / UNKNOWN |
| 5. Does your child put dust, dirt, or paint chips in his/her mouth? | YES / NO / UNKNOWN |
| 6. Does your child live near an active lead smelter, battery recycling plant, or similar industry? | YES / NO / UNKNOWN |
| 7. Do you use folk remedies or medicines, or eat food stored in foreign-made pottery or metal containers (excluding food canned in the U.S./Canada)? | YES / NO / UNKNOWN |
| 8. Are there plastic mini blinds in your home, which are chipping or cracking? | YES / NO / UNKNOWN |

Lead risk: HIGH: ≥ 2 risk factors – lead level; MODERATE: 1 risk factor– lead level or re-screen in 6 months

Tuberculosis Screen (All patients)

- | | |
|---|---------------------------|
| 1. Has your child been in contact with anyone who has active tuberculosis? | YES / NO / UNKNOWN |
| 2. Has your child been in close contact with anyone who has been in prison (past five years)? | YES / NO / UNKNOWN |
| 3. Has your child been in close contact with anyone who has HIV infection, is homeless, lives in a nursing home, uses illegal drugs, or is a migrant farm worker? | YES / NO / UNKNOWN |
| 4. Child recently traveled to Asia, the Middle East, Africa, Eastern Europe, Latin America? | YES / NO / UNKNOWN |
| 5. Family member in close contact recently traveled to location in question above? | YES / NO / UNKNOWN |

Tuberculosis risk: HIGH (1 or more risk factors = YES to any question) – TB test ordered
 (Continue to reverse side)

PATIENT'S IDENTIFICATION <i>(Use this space for Medical Imprint)</i>		
RECORDS MAINTAINED AT:		
PATIENTS NAME	SEX	
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSORS NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

PEDIATRIC QUESTIONNAIRE AGE 15 MONTHS AND OVER

Fluoride Source

1. Fluoride containing bottled water
2. Fluoride rinse at school or toothpaste
3. Other: _____

YES / NO / UNKNOWN
YES / NO / UNKNOWN
YES / NO / UNKNOWN

Nutrition: Does the patient receive the appropriate servings per day of:

- Yes / No** Dairy (Recommended 2 until age 3, then 3-4 until age 9, then 5)
Yes / No Bread/grains (Recommended 3-4 until age 9, then 5)
Yes / No Vegetables (Recommended 4 until age 9, then 5)
Yes / No Meats (Recommended 2 until age 3, then 3-4 until age 9, then 5)
Yes / No Fruits (Recommended 3-4)
No / Yes Soft drinks or juices more than 1-2 times a day? (not recommended)
No / Yes Candy, fats, fried foods, or desserts more than 1-2 times a day? (not recommended)

Elimination: Any changes in the patient's urine output? **Yes / No** Are the bowel movements normal? **Yes / No****Sleep:** Waking at night? **Yes / No** Number of hours sleep per 24 hour period _____**Does anyone smoke at home? Yes / No****Developmental Milestones: (All patients ages 5 and below)**

15 Months	18 Months	24 Months
<input type="checkbox"/> Says 3-6 words <input type="checkbox"/> Understands simple commands <input type="checkbox"/> Indicates wants with gestures <input type="checkbox"/> Scribbles <input type="checkbox"/> Walks alone without help <input type="checkbox"/> Crawls up stairs <input type="checkbox"/> Feeds self with fingers <input type="checkbox"/> Drinks from cup by self <input type="checkbox"/> Tolerates changes	<input type="checkbox"/> Says 4-15 words <input type="checkbox"/> Points to 1-2 body parts <input type="checkbox"/> Follows simple directions <input type="checkbox"/> Imitates crayon stroke <input type="checkbox"/> Runs stiffly <input type="checkbox"/> Shows affection, kisses with pucker <input type="checkbox"/> Feeds self / uses spoon and cup <input type="checkbox"/> Can self-entertain / self-comfort <input type="checkbox"/> Stacks 2-3 blocks <input type="checkbox"/> Kicks / throws ball <input type="checkbox"/> Walks up stairs (holding hand)	<input type="checkbox"/> Says 30-50 words <input type="checkbox"/> 50% of speech understood by strangers <input type="checkbox"/> Uses two word phrases <input type="checkbox"/> Follows two-step commands <input type="checkbox"/> Imitates circular stroke and copies line <input type="checkbox"/> Runs well <input type="checkbox"/> Jumps in place <input type="checkbox"/> Climbs up and down stairs <input type="checkbox"/> Feeds self, uses utensils well <input type="checkbox"/> Helps with undressing <input type="checkbox"/> Tolerates "no" <input type="checkbox"/> Stacks 3-4 blocks
3 Years	4 Years	5 Years
<input type="checkbox"/> Kicks ball <input type="checkbox"/> Pedals tricycle <input type="checkbox"/> Jumps in place <input type="checkbox"/> Copies circle <input type="checkbox"/> Builds a tower of 8-10 cubes <input type="checkbox"/> 75% of speech understood by strangers <input type="checkbox"/> Speaks in sentences <input type="checkbox"/> Knows name, age, sex <input type="checkbox"/> Know 1-3 colors <input type="checkbox"/> Feeds self <input type="checkbox"/> Puts on some clothes <input type="checkbox"/> Describes action in book <input type="checkbox"/> Brushes teeth <input type="checkbox"/> Washes and dries hands	<input type="checkbox"/> Jumps forward <input type="checkbox"/> Stands and hops on one foot <input type="checkbox"/> Copies circle/cross <input type="checkbox"/> Conversational give and take <input type="checkbox"/> Tells story <input type="checkbox"/> Counts to 5 <input type="checkbox"/> Speech fully understood by strangers <input type="checkbox"/> Plays make believe/dress up <input type="checkbox"/> Brushes teeth <input type="checkbox"/> Dresses and undresses self <input type="checkbox"/> Uses toilet by self <input type="checkbox"/> Climbs stairs alternating feet <input type="checkbox"/> Recognizes letters & numbers <input type="checkbox"/> Knows 3-4 colors	<input type="checkbox"/> Skips <input type="checkbox"/> Recognizes possessions (shoes, lunchbox) <input type="checkbox"/> Copies triangle and square <input type="checkbox"/> Draws person with 3-4 parts after head <input type="checkbox"/> Knows 4-5 colors <input type="checkbox"/> Counts to 10 <input type="checkbox"/> Recognizes most letters <input type="checkbox"/> Dresses and undresses without help <input type="checkbox"/> Understands right from wrong <input type="checkbox"/> Waits turn in games <input type="checkbox"/> Brushes teeth without help

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