Bryan CRETE AREA MEDICAL CENTER

Health Maintenance Questionnaire
9-10 YEARS

Patient Name _____

Who accompanied child today?
(name and relationship to child) _____

Who does child live with? _____

Any Chronic health problems? _____

Concerns about the above health problems? _____

New or recent health concerns? _____

Any concerns with child's diet? _____

Does your child take vitamins? Yes No

Please list current medications: _____

_____

_____

_____

Any allergies to medicine? _____

_____

_____

Behavioral/Development Assessment:
What grade is your child in (or entering)? _____

What school does he/she attend? _____

Any concerns about school performance?: _____

_____

If you do not understand any of these questions, please ask your nurse.

Any concerns about sleep habits? _____

_____

List your child's interests & activities _____

_____

_____

What does your child do for exercise & how often? _____

_____

Does your child enjoy books/reading? Yes No
Is he/she developing positive peer relationships? Yes No
Do you have any concerns about hearing or vision? Yes No

If yes, please explain: _____

_____

Tuberculosis Screening Questionnaire:

Does your child have contact with adults with TB infection?

Yes No

Is child or parent are from region of world with high prevalence of TB?

Yes No

Is child frequently exposed to immunosuppressed persons, homeless people, nursing home residents, or migrant workers?

Yes No

Does either parent or other individual living in home work in a medically related field or have contact with institutionalized individuals or nursing home residents?

Yes No

Cholesterol Risk Assessment Questionnaire:

Parent or Grandparent with heart disease or stroke under the age of 55?

Yes No

Parent or Grandparent with elevated cholesterol >240?

Yes No

If you do not understand any of these questions, please ask your nurse.