

COMPLETE BOTH SIDES OF THIS FORM, PLEASE

Patient's Name: _____

Date: _____

Completed by: _____

Relationship to patient: _____

HEALTH ASSESSMENT SCREENING QUESTIONNAIRE FOR 6-11 YEARS

Social/Environment

Home occupants (if multiple homes, list separately)

Pets _____ Please check if changes in family setting since last exam _____

Yes ___ No ___ Is your child exposed to tobacco products?

Yes ___ No ___ Does either parent smoke?

Hearing:

Yes ___ No ___ Is there any family history of hearing impairment?

Yes ___ No ___ Any concern today regarding your child's hearing?

Vision

Yes ___ No ___ Does your child wear glasses or contact lenses? Date last vision exam: _____

Yes ___ No ___ Any family history of eye problems other than near or farsightedness?

Yes ___ No ___ Any concerns today regarding your child's vision?

Immunizations:

Yes ___ No ___ Has your child ever had a serious reaction to prior immunizations?

Yes ___ No ___ Has your child had Chicken Pox?

Tuberculosis screening: While the vast majority of children in the U.S. have little or no risk of becoming infected with tuberculosis, a few children may be at increased risk and should have a tuberculin skin test done. Please answer the following questions to help us determine your child's risk factors.

Yes ___ No ___ Is the child in close contact to a person sick with active TB disease?

Yes ___ No ___ Does the child have or is at risk to have HIV?

Yes ___ No ___ Was the child or the child's parents born outside of the United States?

Yes ___ No ___ Is the child exposed to a person in jail or a person who has been in jail in the past five years?

Yes ___ No ___ Is the child exposed to a person who has HIV, who is homeless or who lives in a nursing home or another group home?

Yes ___ No ___ Is the child exposed to drug users or migrant farm workers?

Yes ___ No ___ Does the child have a health problem that lowers the immune system?

Yes ___ No ___ Does the child live in a community that has a high risk for TB?

Yes ___ No ___ Has the child traveled to or had a visitor from any foreign country since the last visit?

Yes ___ No ___ Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss, or fatigue) or any abnormal chest x-ray?

PLEASE TURN PAGE OVER

Cholesterol screening may be recommended between the ages of 2-18 years if any of the following risk factors are present:

Yes___No___ Is there any history of heart disease, heart attack, or surgery such as angioplasty or bypass, or stroke in a parent or grandparent when that person was less than 55 years old?

Yes___No___ Does either parent have a high blood cholesterol level?

Urinalysis: This is a routine screening for signs of infection, kidney disease and diabetes. Screening is done once between ages 3 and 5 and at all adolescent check-ups.

Yes___No___ Any concerns regarding your child's urine today?

Guns

Yes___No___ Do you have guns at your home?

Yes___No___ If so, are they locked up and ammunition separately locked up?

Sports Related Questions: The following questions screen for risk factors for your child participating in sports:

Yes___No___ Has your child ever felt dizzy or passed out during exercise?

Yes___No___ Has your child had a concussion or ever been unconscious?

Yes___No___ Does your child cough frequently or get unusually short of breath with exercise?

Yes___No___ Has your child ever had chest pain during or after exercise?

Yes___No___ Is there a family history of cardiomyopathy, long Q-T syndrome or Marfan's Syndrome?

Yes___No___ Is there a family history of sudden, unexplained death?

Yes___No___ Has your child had any serious broken bones or sprains?

11/2007

6-11 Years

Reviewed:_____