Health Maintenance Visit
6 YR - 11 YR

Na ____________________

Date:____________________ DOB ____________________

MEDICAL RECORDS COPY

PARENT: PLEASE FILL OUT THIS SIDE DOWN TO THE DOUBLE LINE (PLEASE FILL IN AND CIRCLE ANSWERS)

Nutrition (Subjective)

1. PARENT: HOW MANY SERVINGS OF EACH OF THE 4 FOOD GROUPS DOES YOUR CHILD EAT EACH DAY?
(Please write number of servings in space provided after reviewing examples of serving size for this age group.)

Milk	Meat	Fruits and Vegetables	Grains
1 cup milk , yogurt	2 oz cooked, lean meat fish, poultry	1/2 cup cooked fruit or vegetable	1 slice bread
1 1/2 oz cheese	2 eggs or 1 c. dried beans, peas	1 cup raw fruit or vegetable	1 cup ready to eat cereal
1 3/4 cup ice cream	2 slices (2 oz) cheddar chees`		1/2 cup hot cereal
2 cups cottage cheese	1/2 cup cottage cheese		
1 cup pudding	4 Tbsp peanut butter		
_____ # of servings my child eats each day	_____ # of servings my child eats each day	_____ # of servings my child eats each day	_____ # of servings my child eats each day

2. List snack foods

3. Does your child have any problems with eating? Yes No

ELIMINATION

4. Does your child have problems with urination, diarrhea, constipation, wetting or soiled pants? Yes No

BEHAVIOR

5. Does your child brush his teeth regularly? Yes No
6. Has your child learned to floss his/her own teeth? Yes No
7. Your child sleeps from ____________________pm to _______________ am
8. Any problems with sleeping? Yes No

BEHAVIOR/DEVELOPMENT

9. Has your child learned to ride a bike well? Yes No
10. Does your child enjoy games with other children his/her age? Yes No
11. Does your child express his/her grief and anger? Yes No
12. Does your child show curiosity? Yes No
13. Does your child like to be alone? Yes No
14. Does your child talk things over with you? Yes No
15. Does your child usually accept reasonable explanations? Yes No
16. Is your child doing well in school? Yes No
17. Name of school:____
18. Is there any adult at home when your child gets home from school? Yes No
19. Is there anything about your child that worries or upsets you? Yes No

If so, what

20. Do you feel your child is developing normally? Yes No

ILLNESS

21. If your child is on any medicines, name them: ____________________
22. Has your child had any serious illnesses or accidents since the last check up? Yes No

REVIEW OF SYSTEMS (Check if your child has had any of the following since the last visit.)

___Headaches
___Head injury/unconsciousness
___Convulsion or seizures
___Ear infections or earaches
___Hearing problems
___Crossed eyes/vision problems
___Persistent nosebleeds
___Strep / sore throats
___Teeth problems
___Bleeding/sore gums
___Speech problems
___Wheezing or trouble breathing
___Swollen glands
___Cannot keep up with friends when playing
___Stomach pains
___Frequent colds or coughing
___Broken bones or sprains
___Swollen or painful joints/limping
___Accidents/injuries
___Recent change in family/home
___Anemia
___Loses balance
___Allergies
___Skin rashes or other problems
___Depression
___Recent weight gain/loss
___Frequent nasal congestion

CHILD INVERVIEW:

23. Who is your best friend? ____
24. What do you like most about school? ______________________________ Least? ____________________

OBJECTIVE:

NURSING DIAGNOSIS:

PLAN (Anticipatory guidance checklist on page 1)

Physician Signature ____________________