

Name: _____ Date of birth: _____

Health Status Questionnaire – 7-10 Years

Child lives with: mother father both parents other: _____

School: public private chartered home school

Grade: K 1st 2nd 3rd 4th 5th 6th

Performance: excellent good fair poor failing

Eating habits:

___ regular meals ___ snacks ___ grazes ___ skips meals ___ picky
___ adequate fruits/veggies ___ mostly meat/carbs ___ fast food > 2x week

Milk/dairy products: ___ times per day ___ vegetarian

Activity: regular exercise active sports sedentary cannot tolerate exercise

Voiding habits: normal bedwetting accidents during day

Stool pattern: regular irregular hard constipation diarrhea

Sleep: 9-10 hours <8 hours difficulty falling asleep wakes at night

Development concerns: none speech motor social cognitive vision hearing

Firearms/guns in home: Y N Locked away: Y N

Insect protection: Y N Helmet use: Y N

Sunscreen: Y N ATV/motorcycle: Y N

Seat belt use: Y N Passive smoke exposure: Y N

Dental visit: Y N

Do you limit your child to no more than 1-2hrs of TV/computer/video games? Y N

Tuberculosis (Tb) Screen Questions:

Has your child ever received BCG (a Tb vaccine given in some foreign countries)? Y N

Has there ever been tuberculosis/Tb in any household member? Y N

Was your child born or traveled for longer than 2 weeks to a country at high risk for tuberculosis (countries other than U.S., Canada, Australia, New Zealand or western Europe)? Y N

Dyslipidemia screen:

Child's parents/grandparents had stroke/ heart attack before age 55? Y N

Child's parent with elevated cholesterol(>240) or taking cholesterol medicine? Y N

(continue on back)

Review of Systems:

<i>Const</i>			<i>GI</i>			<i>Heme</i>		
fever	y	n	stomachache	y	n	excessive bleeding	y	n
fatigue	y	n	constipation	y	n	excessive bruising	y	n
weight loss	y	n	nausea	y	n	pale	y	n
weight gain	y	n	vomiting	y	n	swollen		
			diarrhea	y	n	lymph nodes	y	n
<i>ENT/eye</i>			<i>Skin</i>			<i>GU</i>		
sore throat	y	n	wart	y	n	genital swelling	y	n
stuffy nose	y	n	rash	y	n	genital redness	y	n
runny nose	y	n	eczema	y	n	urination pain	y	n
earache	y	n	suspicious					
poor hearing	y	n	lesion	y	n	<i>Allergy</i>		
eye irritation	y	n				sinus congestion	y	n
snoring	y	n	<i>Musc-skel</i>			food reaction	y	n
bloody nose	y	n	limp	y	n	hives	y	n
<i>Resp</i>			in-toeing	y	n	hay fever	y	n
cough	y	n	joint pain	y	n	<i>Mental health</i>		
night cough	y	n	back pain	y	n	mood swings	y	n
exercise coughy	n					depression	y	n
wheezing	y	n	<i>Neuro</i>			suicidal thought	y	n
labor breathingy	n		clumsiness	y	n	racing thought	y	n
<i>CV</i>			seizures	y	n	anger	y	n
chest pain	y	n	weakness	y	n	compulsive habits	y	n
tires easily	y	n	toe-walking	y	n	anxiety	y	n
palpitations	y	n	headaches	y	n			
dizziness	y	n						

Do you have any concerns about your child? _____

If your child has asthma, history of wheezing or uses inhalers/breathing treatments, please answer the following questions:

Cough/wheezing: 0-2 days/week >2 days/week daily throughout day

Nighttime cough: 0-1 night/month 2-3 nights/month 4 nights/month >1 night/week

Interferes with normal activity: no limitations minor some extreme

Rescue inhaler (albuterol, Proair, Xopenex, Ventolin, Proventil) use:

0-2 days/week >2 days/week daily several times/day

Oral steroid courses: 0-1X/year 2-3X/year >3X/year

Asthma hospitalizations past 6 months: 0 1 2 3