



7-8 Year Health Maintenance Questionnaire

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

Does your child or any household member
drink water from a private well?
(consider vacation homes, relative's or
friend's home, daycare or school)

Yes No

Please list current medications: _____

Any allergies to medicine? _____

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

Behavioral/Development Assessment:

What grade is your child in (or entering)? _____

What school does he/she attend? _____

Any concerns about school performance?: _____

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

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