



## 9-10 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 from a private well?  
(consider vacation homes, relative's or  
friend's homes, daycare or school) 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? \_\_\_\_\_

Any concerns about sleep habits? \_\_\_\_\_

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

List your child's interests & activities

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What does your child do for exercise & how often?

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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:

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**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.*