6–10 Years

Department of State Health Services
Child Health Record
Preventive Health Visit

Client Information

Name: ____
DOB: _______ /_______/ ______ Age: __________Sex: __________
SSN/Record No.: ____________________________________
Race/Ethnicity: ____________________________________
Informant/Relationship: _____________________________
Medical Home: _____________________________________

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother ____ Father ____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: ______________________
Total children living in home: ____________________
Primary caretaker for this child: __________________
Relationship: _____________________________________
Family's concerns/problems:

Mental Health

(+ indicates need for futher assessment)

____Sleep Problems
____Behavior/problems
____Relationship problems with parents, siblings, peers
____Problems in school
Grade Level____________
____Special education classes
____No/excessive extracurricular activities
____Substance abuse/use
____Self-concept problems

Comments:

Child's Health

Allergies:
Does the system review note any problems or parent concerns: _____Y _____N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly — Type/Reason:

Dental Care/sealants:

Physical Examination

Temp _________ Pulse ____________Resp ____________
BP ___________ Height ___________Weight___________
(%)___________ (%) ______________(%)_____________

N	A	NE		N	A	NE	
____	__	___	Appearance	____	__	___	Heart/pulses
____	__	___	Head/fontanels	____	__	___	Lungs
____	__	___	Skin/nodes	____	__	___	Abdomen
____	__	___	Eyes	____	__	___	Genitalia/anus (Tanner stage)
____	__	___	Ears	____	__	___	Spine
____	__	___	Nose	____	__	___	Extremities
____	__	___	Mouth/throat				**Neurologic:**
____	__	___	Teeth	____	__	___	Muscle tone
____	__	___	Neck	____	__	___	DTRs
____	__	___	Chest/breasts (Tanner stage)				

Additional documentation:

Nutrition

Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group* _____Y _____N
**If answered yes, further assessment needed.*
Usual Servings Per Day:
____Dairy ____Vegetables __ Fruits
____Breads, cereal, rice, and pasta
____Meat, poultry, fish, eggs, and dry beans

Sensory

Vision Screen: _____Normal ____ Abnormal
Hearing Screen: _____Normal ____ Abnormal
Screen used: _____Hearing Checklist for Parents

Health Education

Injury Prevention
____Seat belt/auto safety
____Bicycles/ATV
____Athletics
____Water safety
____Smoke detectors
____Firearm safety

Behavior
____Substance abuse
____Tobacco use
____Security
____Discipline patterns
____Responsibility

____Communication/conflict resolution

Health Promotion
____Limit TV viewing
____Passive smoking
____Regular exercise
____Pubertal changes/sexuality
____Dental care/sealants

Nutrition
____Healthy diet/snacks
____Junk food
____Iron-rich foods

Assessment

Plan

Dental referral made: ___Y ___N
Immunizations: ___Up to date ___To be given today ___ Deferred
Explain:
Lab:
Hct/Hgb ______ Lead _____________
Next appointment:

Date: ________________ Signature/Title: ______________________________ Signature/Title ____________________________________

6–10 Years

If used for documentation:________________________

Patient's Name: ________________________

Date: ________________________

Key Elements

Systems Review

Skin: Rashes, infections

Ears: Hearing or ear problems

Eyes: Eye discharge, blinking, tearing

Nose/Mouth/Throat/Teeth: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing

Gastrointestinal: Bowel movement frequency, problems/concerns, encopresis

Genitourinary: Dysuria, pubescent changes, penile/vaginal discharge or spotting, enuresis

Neuromuscular: Seizures

Musculoskeletal: Fractures, sprains, sport injuries

Progress Notes