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:

Const			*GI*			*Heme*		
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
ENT/eye						*GU*		
sore throat	y	n	*Skin*			genital swelling	y	n
stuffy nose	y	n	wart	y	n	genital redness	y	n
runny nose	y	n	rash	y	n	urination pain	y	n
earache	y	n	eczema	y	n			
poor hearing	y	n	suspicious			*Allergy*		
eye irritation	y	n	lesion	y	n	sinus congestion	y	n
snoring	y	n				food reaction	y	n
bloody nose	y	n	*Musc-skel*			hives	y	n
Resp			limp	y	n	hay fever	y	n
cough	y	n	in-toeing	y	n			
night cough	y	n	joint pain	y	n	*Mental health*		
exercise cough	y	n	back pain	y	n	mood swings	y	n
wheezing	y	n				depression	y	n
labor breathing	y	n	*Neuro*			suicidal thought	y	n
CV			clumsiness	y	n	racing thought	y	n
chest pain	y	n	seizures	y	n	anger	y	n
tires easily	y	n	weakness	y	n	compulsive habits	y	n
palpitations	y	n	toe-walking	y	n	anxiety	y	n
dizziness	y	n	headaches	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 nightly
Use of rescue(albuterol) inhaler: <2days/week 2-4days/week daily several times/day
Interferes with normal activity: no limitations minor some severe
Oral steroid use: 0-1X/year 2-3X/year >3X/year
ER visits past year: 0 1 2 >3
Asthma hospitalizations past 2 years: 0 1 >2
Controller(steroid) inhaler: never prescribed not currently taking
taking every once in awhile taking regularly