4 Year Health Maintenance Form

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? ____

Does your child currently go to preschool? Yes No

Any developmental concerns? ____

____

Has your child had a vision screening? Yes No

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? Yes No
(consider vacation homes, relative's or friend's homes, daycare or school)

Medications:
Please list current medications: ____

____

____

Any allergies to medicine? ____

____

Turn Over Please

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

Does your child:

Alternate feet going up and down stairs?	Yes	No
Hop in one place?	Yes	No
Stand on one foot for 2 seconds?	Yes	No
Ride a tricycle?	Yes	No
Copy a circle?	Yes	No
Copy a cross?	Yes	No
Draw a person with 3 parts?	Yes	No
Speak clearly?	Yes	No
Ask about meanings of words?	Yes	No
Name 4 colors?	Yes	No
Wash and dry hands?	Yes	No
Brush his/her teeth?	Yes	No
Dress/undress themself except laces and buttons if given enough time?	Yes	No

Tuberculosis Screening Questionnaire:

Does your child have contact with adults with TB infection?

Yes No

Is child or parent from a region of the world with a 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.