

5 to 9 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)	<input type="checkbox"/> FLUORIDE <input type="checkbox"/> REFERRED
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PHYSICAL EXAM

HEIGHT	WEIGHT	BLOOD PRESSURE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> U/A _____ (5 yrs & as indicated)	<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo. @ 36-72 mo. if not screened; verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
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SENSORY SCREEN

NORMAL VISION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED RESULTS: RIGHT ____ LEFT ____ BOTH ____	NORMAL HEARING? <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL (RIGHT ____ LEFT ____) <input type="checkbox"/> REFERRED
DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
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HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> DENTAL HYGIENE <input type="checkbox"/> PEER RELATIONS <input type="checkbox"/> LIMIT SETTING <input type="checkbox"/> NUTRITION <input type="checkbox"/> COMMUNICATION <input type="checkbox"/> PARENTAL ROLE MODEL <input type="checkbox"/> REGULAR PHYSICAL ACTIVITY <input type="checkbox"/> SCHOOL PERFORMANCE <input type="checkbox"/> SAFETY: WATER, SEAT BELTS, SKATE BOARD, BICYCLE
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DIAGNOSIS:
PLAN:
SIGNATURE:

