Patient intake 7-10 YEAR OLD HEALTH SUPERVISION

Please either circle or fill in responses

Patient Name: _____ Date of Birth: _____ Allergies: _____

Source of information for this visit: Mother Father Other: _____

Chief complaint/Appointment goal: _____

Is this visit related to an injury? YES NO

Patient (Caregiver) Preferences and Learning Needs Assessment (update annually):

- Preferred name of patient: _____
- Preferred spoken language: _____
- Preferred written language: _____

Preferred mode of communication:
Verbal Sign language Written Assistive Communication Device

Preferred method of learning:
Demonstration Printed materials Verbal explanation Video Internet/Patient Portal

Preferred method of communication:
No preference Printed letter Phone call Patient portal

Any Cultural or Religious beliefs that may affect care? None.
If Yes – please explain _____

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
Never Rarely Sometimes Often Always;

Barriers to learning? None. If yes, please explain: _____

Do you suspect your child is in pain? ◆ **Staff- Evaluate pain with DVPRS or Numeric Scale***	YES	NO
Has the patient been seen elsewhere since their last clinic visit with us?	YES	NO
If yes, explain: _____	(◆ Staff- Request Records*)	

Review of Symptoms (Place an "X" in all categories that apply):

Hearing Concerns		Limb Pain		Ear Drainage	
Vision Concerns		Syncope (Fainting)		Sore Throat	
Snoring		Fever		Cough	
Chest Pain or Pressure		Headache		Wheezing	
Difficulty Breathing		Sinus Congestion Present		Vomiting	
Constipation		Nasal Discharge		Diarrhea	
Change in Urinary Habits		Ear Pain		Abdominal Pain	
Excessive Thirst		Pulling on Ears		Decreased Appetite	

Other: _____

Biological Females: Have periods started? YES NO

If yes, when did patient's last menstrual period start: _____

Family Screening

Are any members of the household currently <u>deployed or on extended duty</u> outside of the immediate area?	**YES**	**NO**
Is the caregiver in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?	**YES**	**NO**

Nutrition

Number of substantial breakfasts (# of days per week):_____

Number of Sweetened Drinks per day? _____

Amount of Fruit servings per day? _____

Amount of Vegetable servings per day? _____

Number of Meals with Family per week? _____

Oral Health

Has your child had a dental cleaning/ check-up in the past 6-12 months?

Yes. No.

Does your child brush using fluoride toothpaste?

Yes. No.

Do you have any concerns about your child's oral health?

Yes. No.

Access to Food

- Within the past 12 months I/we were worried whether our food would run out before we got money to buy more. Often True Sometimes True Never True
- Within the past 12 months the food I/we bought just didn't last and I/ we didn't have the money to get more. Often True Sometimes True Never True

Tuberculosis (TB) Screen

Has a family member or contact had active tuberculosis? Yes. No.
Has a family member had a positive tuberculin skin test? Yes. No.
Was your child born in a high-risk country? Yes. No.
Has your child traveled to a high risk country for more than one week? Yes. No.

Developmental Milestones

Does your child do chores at home when asked?	YES	NO
Gets along with family and friends?	YES	NO
Engages in after school activities?	YES	NO
Reading and doing math at grade level?	YES	NO
Has self-positive image?	YES	NO

Exceptional Family Member Program (EFMP)

Is the patient enrolled in the EFMP program?	**YES**	**NO**

Family history/Surgeries. Check all that apply.

Family History	**Patient Surgeries**
☐ Asthma ☐ Allergies ☐ SIDS ☐ Birth Defects ☐ Cancer ☐ Heart Attack (before the age of 50) ☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease ☐ Diabetes ☐ Vision Problems ☐ Hearing Problems ☐ Mental Health Concerns (ADHD, Anxiety, Bipolar, Depression, Intellectual Disability, Suicide, etc.) ☐ Alcohol/Substance Abuse ☐ Genetic/Metabolic Disease ☐ Other: _____	☐ NO History of Surgery ☐ Ear Tubes ☐ Tonsillectomy ☐ Adenoidectomy ☐ Circumcision ☐ Appendectomy ☐ Other: _____
◆ **To be Completed by Corpsmen: **If parent/guardian placed a checkmark to any history item above, PLEASE document family member type that correlates to each in the space below.**	

Home Environment

Who does the patient live with? _____

Household alcohol concerns?	YES	NO
Household members who Smoke	YES	NO
Vape?	YES	NO
Does the child attend School?	YES	NO
• Grade? • Name of School? • Activities child participates in?		

<u>You are DONE! Please keep your paperwork with you and wait to be called back.</u>

***** If you feel you received exemplary care from our staff today, PLEASE ask our front desk staff on the way out about our ICE and DAISY Recognition Programs! *****

(Below for Office Staff)

Weight: _____kg

Height: _____cm

Heart Rate: _____ bpm

BP: _____/_____

Respiratory Rate: _____ breaths/min

O2 sat (if Indicated): _____

Temperature: _____
(Temporal, oral, tympanic, axillary, rectal)

Vision: Corrective lenses? YES NO

Visual Acuity:

RIGHT EYE: 20/____, left (OS) 20/___, both (OU) _____

Important Notes from Corpsmen to Provider:

PARENT HANDOUT

7-10 Year Old Health Supervision

Your child's growth:

Weight:_____lb. Percentile:_____

Height: _____in. Percentile:_____

Create a MHS Genesis Patient Portal Account

1. Scan QR Code with camera
2. Go to website
3. Sign Self-Service Consent
4. Click "Need an Account"
5. Complete the registration process

Click on me to go to the "**HealthyChildren.org**" Website! An American Academy of Pediatrics (AAP) guide to your child's milestones, growth and development. Search by age.

Staying Healthy

- Eat together often as a family.
- Limit soft drinks, juice, candy, chips, and high fat food.
- Include 5 servings of vegetables. and fruits at meals and snacks daily.
- Limit TV and computer time to 2 hours a day.
- Encourage your child to be active for at least 1 hour daily.

Your Growing Child

- Give your child chores to do and expect them to be done.
- Hug, praise, and take praise in your child for good behavior and doing well in school.
- Brush teeth twice daily with pea-sized amount of toothpaste with fluoride and spit out toothpaste. Help your child floss once each day.
- Take your child to the dentist at least annually.

Safety

- Your child should always ride in the back seat and use a booster seat until the vehicle's lap and shoulder belt fit.
- Teach your child to swim.
- Watch your child around water.
- Use sunscreen when outside.
- Have your child wear a good-fitting helmet and safety gear for biking, skating, etc.
- If you have a gun, store unloaded and locked with the ammunition locked separately.
- Teach your child about how to be safe with other adults: no one should ask for a secret to be kept from parents, no one should ask to see private parts, and no adult should ask for help with their private parts.

Immunizations

- Annual Influenza (2 doses for first time influenza vaccination for 8 years and under)
- Gardasil-9 series (Human Papilloma Virus) - 2 doses separated by 6 months for ages 9-14

Next health supervision appointment: Annually (Once Every year!)

Patient specific guidance:

_____

_____

_____