# 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?<br>◆ **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 |
| **Eats healthy foods and snacks?** | YES | NO |

## Exceptional Family Member Program (EFMP)

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

**Family history/Surgeries.** Check or circle all that apply.

| Family History | **Patient Surgeries** |
|---|---|
| ☐ Asthma<br>☐ Allergies<br>☐ SIDS<br>☐ Birth Defects<br>☐ Cancer<br>☐ Heart Attack (before the age of 50)<br>☐ High Blood Pressure<br>☐ High Cholesterol<br>☐ Kidney Disease<br>☐ Diabetes<br>☐ Vision Problems<br>☐ Hearing Problems<br>☐ Mental Health Concerns (ADHD, Anxiety, Bipolar, Depression, Intellectual Disability, Suicide, etc.)<br>☐ Alcohol/Substance Abuse<br>☐ Genetic/Metabolic Disease<br>☐ Other: _____ | ☐ NO History of Surgery<br><br>☐ Ear Tubes<br>☐ Tonsillectomy<br>☐ Adenoidectomy<br>☐ Circumcision<br>☐ Appendectomy<br>☐ 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?<br>• Name of School?<br>• 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:**

_____

_____

_____

**Pediatric Appointment Reminder**

To expedite your visit, please visit this link:
https://bremerton.tricare.mil/Health-Services/Childrens-Health/Pediatrics

OR

Scan this QR code to **fill out the intake paperwork required for your appointment**. You can bring a printed copy or send it to us electronically via the Patient Portal.

**Date: _____ Time: _____**

**Appointment for: _____**

**Location: Pediatric Clinic, Bldg 17, 3rd floor**

**Instructions:**

- **Arrive to your appointment 10 min early**
- **Please call the PEDS Clinic with any questions or concerns: 360-475-4236**