Name FMP/SSN last DOB:

Email Address : Contact Phone Number:

6-11 YEAR VISIT

Do you have any specific concerns today? _____

_____

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions	Surgeries/ Hospitalizations	Dates	Family History (biological siblings, parents, grandparents) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
Hayfever/allergies **Asthma** **ADHD** **Overweight** **Chronic ear infections** **Other:**	Example Circumcision		**Allergies** **Asthma** **Diabetes** **Heart Disease** **Obesity**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):**

Any hospitalizations, specialty care or ER visits since last appointment? ❑Yes ❑No Please specify _____

Check if anyone in the family has had:

□ High Blood Pressure □ Diabetes □ Heart attack < 50 years □ Sudden Death □ Mental Illness

□ High Cholesterol □ Obesity □ Genetic or Metabolic Disease □ Long QT syndrome □ Hypertrophic Cardiomyopathy

Please list any known **allergies** your child has (drug, food, latex)

_____

Is your child enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? ❑ Yes ❑ No

Is the child's sponsor currently deployed? ❑ Yes ❑ No Is this visit **deployment** related? ❑ Yes ❑ No

Are your child's immunizations up to date? ❑ Yes ❑ No ❑ Unsure

Who does your child live with? _____

Does your child attend: ❑ Child-care ❑ Public/private school ❑ Home-schooled (Grade: _____)

Does anyone in the family smoke? ❑ Yes ❑ No

Do you & your child feel safe at home? ❑ Yes ❑ No

What is your preferred method for learning: ❑ Verbal ❑ Written ❑ Visual ❑ Other: _____

Preferred language: ❑ English ❑ Other: _____

Please See Reverse Side

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

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Are there cultural or religious considerations that affect your child's healthcare? ❑ Yes ❑ No_____

Ethnic Origin ❑Filipino ❑Hispanic ❑ Asian/Pacific Islander ❑Southeast Asian ❑ Other ❑ Unknown ❑ Decline to Respond

Race ❑ Asian/Pacific Islander ❑ African American ❑ Caucasian ❑ Western Indian ❑ Other ❑ Unknown ❑ Decline to Respond

Diet/Exercise History:

Current Diet Less Than **5** Servings a day Of Fruits and/or vegetables ❑ Yes ❑ No

Current Diet High in Fat Content and Includes High Fat Snacks❑ Yes ❑ No

Current Diet High Fat and includes Frequent Fast Foods ❑ Yes ❑ No

Current Diet High Fat and Includes Fried Foods ❑ Yes ❑ No

Days a Week eating Breakfast _____ Days/week Having Dinner with Family _____

Eats Extra Large Portions ❑ Yes ❑ No High Sugar Beverages ❑ Yes ❑ No How many ounces per day? _____
Caffeinated Beverages ❑ Yes ❑ No How many per week? ____

Daily Milk Intake ___ounces per day Type of milk? ❑ Whole ❑ 2% ❑ 1% ❑ Skim

Does your child get at least one hour of physical activity at least 5 times per week? ❑ Yes ❑ No Type of activity: _____

How many hours of exposure to TV/video games/computer time does your child have per day? _____

Does your child have a TV or internet in their bedroom? ❑ Yes ❑ No

Check all of the following that apply for your child:

❑ Appropriate Behavior at Home ❑ Pride in achievements

❑ Appropriate Behavior at School ❑ Talks about activities at school

❑ Appropriate Behavior when playing with friends ❑ Completes school work

❑ Reading and doing math at grade level

Circle if you have any concerns about the following: Bowel movements / Constipation / Sleep problems

Check if your child has had a history of:

□ Trauma □ Fractures □ Fainting during exercise

□ Head Trauma □ Chest pain or discomfort □ Exercise intolerance

□ Concussion □ Palpitations

In the past week, has your child had:

Fever	Yes/No	Duration?_____	Cough	Yes/No	Duration?_____
Headache	Yes/No	Duration?_____	Wheezing	Yes/No	Duration?_____
Congestion	Yes/No	Duration?_____	Vomiting	Yes/No	Duration?_____
Runny nose	Yes/No	Duration?_____	Diarrhea	Yes/No	Duration?_____
Earache	Yes/No	Duration?_____	Abdominal pain	Yes/No	Duration?_____
Pulling at ears	Yes/No	Duration?_____	Appetite Less	Yes/No	Duration?_____
Eye discharge	Yes/No	Duration?_____	Rash	Yes/No	Duration?_____
Sore throat	Yes/No	Duration?_____	Other (describe)_____		

Pre-teen/teen females only (if applicable): Last menstrual period _____