

9 to 13 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.			Tanner Staging:
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

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SENSORY SCREEN

NORMAL <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS: VISION? <input type="checkbox"/> REFERRED 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"/> SEXUAL INFO <input type="checkbox"/> BICYCLE SAFETY <input type="checkbox"/> PEER PRESSURE <input type="checkbox"/> NUTRITION <input type="checkbox"/> COMMUNICATION AFFECTION <input type="checkbox"/> SCHOOL PERFORMANCE <input type="checkbox"/> SMOKING, ALCOHOL, DRUGS <input type="checkbox"/> OTHER

DIAGNOSIS:
PLAN:
SIGNATURE: