Office Use Only:
- ☐ Form Completed
- ☐ NP
- ☐ Existing

GOLDEN BEACH MEDICAL CENTRE

4 Year Old Health Check

This information is private and confidential and is for use in your child's clinical file only.

CHILDS DETAILS - Please print and give as much detail as possible to assist us to provide quality care.

Surname: _____ **Given Name:** _____ **Middle Name:** _____ **Lives With:** _____

Date of Birth _____/_____/_____ **Ethnicity:** ☐ Australian ☐ Aboriginal ☐ TSI ☐ ATSI Other _____

Medicare No: _____ **Ref #** *(next to name)* _____ **Expiry:**_____

16 Digit Health Identifier: _____

Pension/Healthcare Card No: _____ **Expiry:**_____

Do you have private health care fund? ☐ Yes ☐ No **Fund Name:** _____ **Fund Number:** _____

Residential Address: _____ **Town:** _____ **Postcode:** _____

Postal Address: *(if different to home)* _____

Phone: _____ **Mobile:** _____ **Business:** _____ Contact at work? ☐ Yes ☐ No

Email Address: _____ **Do you wish to receive electronic newsletters:** ☐ Yes ☐ No

Next of Kin: _____ **Relationship:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Please list any known allergies and your reactions or list nil known if none: _____

_____

Please list any operations or previous illnesses: _____

FAMILY HISTORY: Please check the most appropriate answer fill out all other areas

Has your child ever had: ☐ Diabetes ☐ Kidney Disease ☐ Asthma ☐ Heart Problems ☐ Cancer ☐ Other
☐ Breast Cancer ☐ Colon Cancer ☐ Stroke ☐ Depression ☐ Epilepsy ☐ High Blood Pressure

Family History: ☐ Unknown *(eg Adopted)* ☐ No significant family history ☐ Other – see list below

Mother: Still alive: ☐ Yes ☐ No **If no Age at Death** _____
☐ Diabetes ☐ Kidney Disease ☐ Asthma ☐ High Blood Pressure ☐ Heart Problems
☐ Breast Cancer ☐ Colon Cancer ☐ Stroke ☐ Depression ☐ Epilepsy ☐ Other Cancer

Father: Still alive: ☐ Yes ☐ No **If no Age at Death** _____
☐ Diabetes ☐ Kidney Disease ☐ Asthma ☐ High Blood Pressure ☐ Heart Problems
☐ Breast Cancer ☐ Colon Cancer ☐ Stroke ☐ Depression ☐ Epilepsy ☐ Other Cancer

Other immediate family member's significant illness: _____

Does your child see any other medical professionals? ☐ Yes ☐ No Name: _____

PLEASE TURN OVER

Please tick all that apply:

Gross Motor: *Does your child*

- ☐ Walk alone up and down stairs, one foot per step
- ☐ Not able to walk up and down stairs with one foot per step
- ☐ Run well on flat surface, turning sharp corners
- ☐ Awkward, heavy running, with lots of arm movements
- ☐ Climb playground ladders and other equipment easily
- ☐ Not able to climb (may be fearful, anxious)
- ☐ Ride tricycle and pedals easily
- ☐ Can't pedal a tricycle
- ☐ Catch, bounce, throw and kick a ball
- ☐ Can't catch, throw or kick a ball

Fine Motor: *Does your child*

- ☐ Hold a pencil between thumb and 1-3 other fingers
- ☐ Not holding a pencil at all, or still holding in a fisted grasp with pencil in palm of hand
- ☐ Draw a basic human figure
- ☐ Not interested in drawing at all
- ☐ Draw other simple pictures (e.g. a house)
- ☐ Not drawing simple pictures
- ☐ Brush teeth with supervision
- ☐ Wipe after using toilet
- ☐ Not assisting or interested in trying to groom and bath
- ☐ Dress except for hard to reach buttons, bows and shoelaces
- ☐ Unable to dress

Talking and Understanding: *Does your child*

- ☐ Use two or more personal pronouns (I, you, he, she etc.)
- ☐ Awkward sentences, missing grammatical elements
- ☐ Name colours and shapes
- ☐ Hold conversations
- ☐ Talks on and on rather than taking turns with talking
- ☐ Tell story in past and future tense
- ☐ Cannot tell a simple story of recent events
- ☐ Repeat back a sentence of 10 sounds
- ☐ Be easily understood by strangers
- ☐ Strangers not able to understand
- ☐ Understand human feelings (e.g. cold, tired, hungry)
- ☐ Give first and last name
- ☐ Limited or very fixed interests
- ☐ Frustration at not being able to express thoughts
- ☐ Understand prepositions (e.g. in, out and beside)
- ☐ Still need to simplify what you say for them to understand

PLEASE TURN OVER

Social: *Does your child*

- ☐ Do up buttons, put on socks and shoes
- ☐ Name age in years
- ☐ Play cooperatively with other children
- ☐ Plays alone or alongside other children rather than cooperating
- ☐ Begin to play games in groups with simple rules
- ☐ Unable to take turns or share
- ☐ Fully undress
- ☐ Create play reflecting complex social situations
- ☐ Persisting frustration if other children attempt to participate in play
- ☐ Cannot separate from parents without crying
- ☐ Play remains repetitive and physical, with little play representing what people do (e.g. shopping, police officer, driving a truck)

Intellectual: *Does your child*

- ☐ Create play with stories with different roles
- ☐ Play doesn't ever represent what people do (e.g. shopping, police officer, driving a truck)
- ☐ Able to compare object as higher or longer
- ☐ Count to five
- ☐ No recognition of written numbers/letters
- ☐ Count objects as well as rote counting
- ☐ Unable to point to and count objects
- ☐ Repeat back four numbers
- ☐ Unable to draw a human face

Physical Activity:

Approximately how much time spent in active or energetic play on a daily basis (OUTSIDE,SPORT)

- ☐ Less than 30 minutes
- ☐ More than 30 minutes but less than an hour
- ☐ More than an hour

Approximately how much time spent in sedentary activities on a daily basis (TV,GAMES)

- ☐ Less than 30 minutes
- ☐ More than 30 minutes but less than an hour
- ☐ More than an hour

Eating Habits:

Please rate your child's appetite: ☐ Poor ☐ Fair ☐ Good

What variety of foods does your child eat - How often do they eat these -

☐ Fruit	2 or more serves per day or less	_____
☐ Vegetables	3 or more serves per day or less	_____
☐ Dairy	2 or more serves per day or less	_____
☐ Meat	2 or more serves per day or less	_____
☐ Fats/Oils	2 or more serves per day or less	_____
☐ Sweets/confectionery	1 or more serves per day or less	_____
☐ Takeaway	2 or more times per week or less	_____

Toilet habits:

Does your child need assistance or can he/she use a toilet independently

- ☐ Assistance required
- ☐ Toilets independently

Does your child wet the bed at all? ☐ Yes ☐ No If Yes how often? _____

PLEASE TURN OVER

Oral Health - Teeth and Gums:

Has your child has visited the dentist: ☐ Yes ☐ No If yes when _____

How often does your child brush their teeth : ☐ Once daily ☐ Twice Daily ☐ More

Hearing:

Do you have parental/other concerns regarding your child's hearing or listening, following instructions or language? If so what are your concerns? _____

_____

_____

Does your child have any history of ear infections, ear discharge, recurrent or chronic otitis media

If so which of the above: _____

_____

_____

Eyesight:

Do you have any concerns about your child's vision (eg. amblyopia, squint, infection, injury) If so what? _____

_____

_____

Do you have a family history of eyesight problems, if so what are they? _____

_____

_____

Does your child take any over the counter medications, vitamins or herbal remedies, if so what are they?_____

_____

_____

Is there any additional health information that you would like or concerns that you would like addressed during this health assessment? _____

_____

_____

This questionnaire remains private and confidential.
The information gathered in this questionnaire is for use in your child's personal medical file only.

PLEASE FILL OUT THE DETAILS AND RETURN TO RECEPTION AT GOLDEN BEACH MEDICAL CENTRE AT LEAST 2 DAYS PRIOR TO YOUR APPOINTMENT

THANK YOU

BE SURE TO FOLLOW US ON FACEBOOK

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