4 Year Old Health Check

GOLDEN BEACH MEDICAL CENTRE

PELICAN WATERS FAMILY DOCTORS

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: ______ Suburb: ______ 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 ◯ Stroke ◯ High Blood Pressure ◯ Cancer ◯ Breast Cancer ◯ Colon Cancer ◯ Epilepsy ◯ Depression ◯ Heart Problems ◯ Other

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 ◯ Breast Cancer ◯ Epilepsy
◯ Depression ◯ Colon Cancer ◯ Stroke ◯ Heart Problems ◯ Other Cancer

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

Other immediate family member's significant illness: ______

Does your child see any other medical professionals? ◯ Yes ◯ No Name: ______

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

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? ____________

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 BRING THE COMPLETED FORM WITH YOU TO YOUR APPOINTMENT
THANK YOU

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