Queensland Government

Health Check 5 - 14 years

Medicare Item No. 228, 715, 10987

Facility: _____

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F

Patient's actual age:

Indigenous status: ☐ Aboriginal only ☐ Torres Strait Islander only ☐ Aboriginal and Torres Strait Islander
☐ Neither Aboriginal nor Torres Strait Islander ☐ Not stated/unknown

Parent / carer's name:	Relationship:	Signature (health check consent):	Date:

Have all the benefits, risks, outcomes and results of this health assessment been discussed and explained to the parent/carer by the clinician? ☐ Yes ○ No

Legend: ○ Indicates a health risk requiring brief intervention, follow up or action. For support see the Chronic Conditions Manual

Family History

Medical History

Current problems/concerns

Allergies

Immunisation status

Has the child had all age related eligible vaccines? ☐ Yes ○ No

Vaccines due:

Initial Date

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HEALTH CHECK 5 - 14 YEARS

Family name:	Given name(s):	URN:

Body measurements

Weight	kg	(..... %le) ☐ Healthy ○ Underweight ○ Overweight
Length	cm	(..... %le) ☐ Healthy ○ Other
BMI (opportunistically 5-15 years)	kg/m²	(..... %le) ☐ Healthy ○ Underweight ○ Overweight
Haemoglobin (10–15 year old girls)	g/L	☐ Normal ○ Other

Initial Date

Special considerations

Is child > 10 years of age with a BMI > 85th percentile? ☐ No (skip section) ○ Yes (continue)
For support see Child Health Check **Special considerations** section in the Chronic Conditions Manual

Blood pressure within limits for age? /	☐ Yes ○ No
Take venous blood for diabetes, dyslipidaemia and NAFLD	☐ BGL ☐ HbA1c ☐ ALT ☐ Lipids
Does the child snore at night?	☐ No ○ Yes
Girls: > 35 days between menstruating on a regular basis **and** » excessive male pattern terminal hair e.g. upper lip, chin? **or** » acne? **or** » male pattern baldness or hair thinning?	☐ No ○ Yes

Initial Date

General appearance

Head, neck and face	☐ Healthy	○ Other _____
Limbs and joints	☐ Healthy	○ Other _____

Initial Date

Skin

Has the child had any skin infections?	☐ No	○ Yes
Inspect skin. Any concerns? Describe	☐ Normal	○ Other _____

Initial Date

Continence elimination

Once at 7 years

Is the child toileting independently?	☐ Y	○ N
Is the child incontinent of urine or faeces?	☐ N	○ Y
Does the child wet the bed?	☐ N	○ Y

Initial Date

Ears and hearing

Family history of hearing loss?	○ Yes ☐ No	History of frequent ENT infections?	○ Yes ☐ No
Speaks in loud or monotone voice?	○ Yes ☐ No	Does not respond to name?	○ Yes ☐ No
Asks for statements to be repeated?	○ Yes ☐ No	Watches others continuously?	○ Yes ☐ No
Has learning problems in class?	○ Yes ☐ No	Withdraws in a group?	○ Yes ☐ No
Parent or teacher reports hearing difficulty?	○ Yes ☐ No	Has disruptive and impulsive behaviour?	○ Yes ☐ No

If 'Yes" to any above OR non-Indigenous child 5 or 12 years of age OR a Aboriginal and Torres Strait Islander child then perform otoscopy, tympanometry and audiometry

Otoscopy (describe)	Right ear:	☐ Healthy ○ Other
	Left ear:	☐ Healthy ○ Other
Tympanometry	Right ear:	☐ Type A ○ Type B ○ Type C
	Left ear:	☐ Type A ○ Type B ○ Type C
Audiometry	Right ear:	4000Hz/25dB ☐ P ○ F 2000Hz/25dB ☐ P ○ F 1000Hz/25dB ☐ P ○ F
	Left ear:	4000Hz/25dB ☐ P ○ F 2000Hz/25dB ☐ P ○ F 1000Hz/25dB ☐ P ○ F

Initial Date

Environment

Is the child exposed to cigarette/vape smoke?	☐ No	○ Yes
How many people live in the house?	_____	
Any observed safety concerns?	☐ No	○ Yes

Initial Date

Physical activity

Is the child physically active for > 1 hrs/day for the last week?	☐ Yes	○ No

Initial Date

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HEALTH CHECK 5 - 14 YEARS

Eyes and vision

Does child have any trouble seeing things?	☐ No ○ Yes
Does child have difficulty seeing what the teacher writes on the board?	☐ No ○ Yes
Does child have trouble seeing the television?	☐ No ○ Yes
Does child get a headache if they read for > 10 minutes?	☐ No ○ Yes
Has child ever had an eye injury?	☐ No ○ Yes
Does parent or teacher report problems with vision, eye appearance or learning?	☐ No ○ Yes
Is there a family history of childhood eye problems?	☐ No ○ Yes
Are there any current medical problems?	☐ No ○ Yes

If "Yes" to any above, perform cover test and visual acuity only. At 6 and 12 years of age perform all below

Cover test	Left eye movement:	Near: ☐ No ○ Yes		Far: ☐ No	○ Yes
	Right eye movement:	Near: ☐ No ○ Yes		Far: ☐ No	○ Yes
Visual acuity (with glasses? ☐ Yes ☐ No)	Right: /	Left: /		☐ 6/9 or less	○ Other (> 6/12)
Red eye reflex	☐ Present	○ Absent			
Fixates and follows an object	☐ Present	○ Absent			

Initial Date

Nutrition

What did the child eat yesterday? Adequate?	☐ Yes	○ No
What did the child drink yesterday? Adequate?	☐ Yes	○ No
Does the child always have access to food?	☐ Yes	○ No

Initial Date

Oral health

Does the child (> 8 yo) or parent (< 8 yo) brush their teeth twice a day?	☐ Yes	○ No
Any toothache or bleeding gums in the last 4 weeks?	☐ No	○ Yes
Has child had a dental check up in the last 2 years?	☐ Yes	○ No

Initial Date

Social-emotional wellbeing

If child < 8 years of age ask: Does the parent have concerns about any of the following?

» Coping?	☐ No	○ Yes
» Relationships (with family or friends)?	☐ No	○ Yes
» Support?	☐ No	○ Yes
» Violence?	☐ No	○ Yes
» Child's behaviour?	☐ No	○ Yes
Observe: Is interaction between parent and child positive?	☐ Yes	○ No
If any concerns raised above, perform SDQ	**Score:** _____	

Initial Date

If child > 8 years of age, with parental consent, ask the child, the following questions and tally responses: (1) Not at all (2) Several days (3) More than half the days (4) Nearly every day

Over the last 2 weeks:

How often did you have little interest or fun in doing things?

How often did you feel hopeless, down in the dumps, sad or slack?

How often did you feel nervous, anxious or on edge?

How often were you not able to stop worrying about things?

Tally first 2 questions: ☐ 1 ☐ 2 ○ ≥ 3

Tally second 2 questions: ☐ 1 ☐ 2 ○ ≥ 3

If score ≥ 3 for first 2 questions OR second 2 questions, perform HEADDS assessment and refer

Alcohol, tobacco and other drugs

Does the child smoke? e.g. vapes, cigarettes, cannabis	☐ No	○ Yes
Does the child drink alcohol?	☐ No	○ Yes
Does the child use drugs or other substances?	☐ No	○ Yes

Initial Date

Family name:	Given name(s):	URN:

Anticipatory guidance

- » Talking and reading to your child
- » Open communication
- » Injury prevention and reducing home hazards
- » Sun protection
- » Strategies for sleeping
- » Limiting screen time
- » Tooth decay
- » Age appropriate healthy eating, fussy eating and strategies
- » School
- » Normal child behaviour and parenting strategies
- » Handwashing
- » Injury prevention
- » For young teen girls discuss women's business
- » For young teen boys discuss men's business

Date

Initial

Note any required actions and transfer to Care Management Plan

Medicare

Medicare item being claimed? ☐ Yes ○ No

All benefits, risks, outcomes and results of this health assessment discussed and explained to carer/parent by clinician? ☐ Yes ○ No (can not claim Medicare)

Written or photocopied feedback of action plan provided to parent? ☐ Yes ○ No (can not claim Medicare)

Medicare claim form signed by parent? ☐ Yes ○ No (can not claim Medicare)

Doctor name	Signature	Date

Signature log

Signature	Name	Date	Initial

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