Well Child Check: 5 Year Visit

Your Child’s Name: ________________________________________________

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT BOTH SIDES.

Can your child skip or jump? Yes No Unsure
Can your child hold a crayon or pencil well? Yes No Unsure
Can your child ride a bike? Yes No Unsure
Can your child draw a person with face, body and limbs? Yes No Unsure
Can you child draw letters or numbers? Yes No Unsure
Does your child speak in full sentences? Yes No Unsure
Does your child know at least 4 colors? Yes No Unsure
Does your child recognize most letters? Yes No Unsure
Does your child engage in make-believe play? Yes No Unsure
Can your child explain the use of a ball or shoe? Yes No Unsure

How many ounces of milk does your child drink in 24 hours? _____________ oz. Whole Low fat Nonfat
Does your child usually drink more than 6 oz. of juice or sweetened drinks daily? No Yes Unsure
Does your child eat meat (such as fish, chicken, beef, or pork)? Yes No Unsure

Does your child typically watch MORE than 2 hours of TV/Computer/Video games, etc. daily? No Yes Unsure
Is your child toilet trained for both day and night? Yes No Partially
Do you usually protect your child with sunscreen/hats/other measures when outdoors? Yes No Unsure
Does your child wear a helmet if he is riding a tricycle or bike? Yes No Sometimes
Do you help your child brush his/her teeth twice a day? Yes No Unsure
Does your child see a dentist at least once a year (every 6 months is best)? Yes No Unsure
Does your tap water contain fluoride? Yes No Unsure

Do you think your child will be ready for kindergarten? Yes No Unsure

Are there guns at your home, or any home your child regularly visits? No Yes Unsure
Does your child have access to a pool that does not have a locked gate? No Yes Unsure
Do you have any other safety concerns at your home? If so, please describe: __________________________________________________________

Who provides day time care for your child?

Is your child on any medications or supplements, including fluoride or vitamins? If so, please list below:

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

May 2015
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**Risk Assessment for Tuberculosis Exposure/Infection:**
Has a family member or contact had tuberculosis disease?  
Yes  No  Unsure

Since your child’s last well check has a family member or contact had a positive tuberculosis test?  
Yes  No  Unsure

Was your child born in a high-risk country (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?  
Yes  No  Unsure

Has your child traveled to (or had contact with people who live in) a high-risk country for more than one week (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?  
Yes  No  Unsure

**Risk Assessment for Abnormal Lipid Profile (such as high cholesterol):**
Did any of your child’s parents or grandparents have significant heart disease at or before 55 years of age (had a heart attack, stroke, angioplasty, angina, or bypass surgery)?  
Yes  No  Unsure

Do either of the child’s parents have a cholesterol level of 240 or higher?  
Yes  No  Unsure

Do you have any concerns about your child’s development, or any other concerns you would like to discuss with your provider? If so, please describe?

_______________________________________________________________________________________
_______________________________________________________________________________________