5 Years – well child care **Patient Name:________________________D.O.B_______**

Please fill in the blank or check the appropriate answer as it pertains to your child.

Household

Who lives in the home (e.g. Father, mother, brother, sister, etc.)? ______________________________________

Does your child attend daycare?____ ▢ Yes ▢No

Development

Tells a story they heard or made up with at least 2 events, like __________________ ▢ Yes ▢No
a cat stuck in a tree and a firefighter saving it
Answers simple questions about a book or story after you read or tell them___________ ▢ Yes ▢No
Keeps a conversation going with more than 3 back and forth exchanges____________ ▢ Yes ▢No
Uses or recognizes simple rhyme (bat-cat, ball-tall)___________________________ ▢ Yes ▢No
Counts to 10____ ▢ Yes ▢No
Names some numbers between 1 and 5 when you point to them__________________ ▢ Yes ▢No
Uses words about time, like yesterday, tomorrow, morning or night_______________ ▢ Yes ▢No
Pays attention for 5-10 minutes during activities, for example, during _____________ ▢ Yes ▢No
story time or making arts and crafts (screen time does not count)__________ ▢ Yes ▢No
Writes some letters in their name____ ▢ Yes ▢No
Names some letters when you point to them_________________________________ ▢ Yes ▢No
Buttons some buttons____ ▢ Yes ▢No
Hops on 1 foot ____ ▢ Yes ▢No
Follows rules or takes turns when playing games with other children_____________ ▢ Yes ▢No
Sings, dances or acts for you____ ▢ Yes ▢No
Does simple chores at home, like matching socks or clearing the table after eating____ ▢ Yes ▢No

Nutrition

Does your child drink milk? If so what kind_____________▢Whole Milk ▢Soy Milk ▢Other __________
Do they drink approximately 16oz (480ml) per day ? ______________ ▢ Yes ▢No
Avoiding excess added sugars (juice, candy, sweets) and animal fats?_ ▢ Yes ▢No
Consuming green vegetables?_________________________________ ▢ Yes ▢No

Bowel habits

How many stools does you child have per day? ____
What do the stools look like (soft, formed, hard)? ____
Is your child showing interest in or has completed toilet training?_____ ▢ Yes ▢No

Sleep Pattern

Sleeps throughout the night in own their bed?____________________ ▢ Yes ▢No

Safety

Is your child's car seat or booster seat in the back seat?___________ ▢ Yes ▢No
Wears a helmet with cycling/boarding/skating?____________________ ▢ Yes ▢No
Is the home childproofed?____________________________________ ▢ Yes ▢No
Is your child exposed to tobacco smoke?_________________________ ▢ Yes ▢No
Are there any improperly stored firearms in the home?____________ ▢ Yes ▢No
Is the hot water temperature set low enough
to prevent accidental burns?______________________________ ▢ Yes ▢No
Are there working smoke detectors in the home?_________________ ▢ Yes ▢No

Please share any concerns that you have about your child here:

____

____

____

Please complete both sides of this form

Please circle any of the questions below to which your answer is "YES".

Lead Risk Assessment:

- Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- Ever lived outside the United States or recently arrived from a foreign country?
- Sibling, housemate/playmate being followed or treated for lead poisoning?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, or eats non-food items?
- Contact with an adult whose job or hobby involves exposure to lead?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
- Uses products from other countries such as health remedies, spices, or food, or stores or serves food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Your child was born in, traveled to or lived in a "tuberculosis high-risk" country?
- Your child has a family member or has had contact with anyone with either active tuberculosis or a history of tuberculosis disease?
- Your child has a family member with a positive tuberculin skin test?

Social Determinants of Health Assessment:

- Within the past 12 months, have you had worries that food would run out before your family got enough money to buy more?
- Within the past 12 months, were there times that food ran out and your family didn't have enough money to get more?
- Have you needed help reading instructions, pamphlets, or other written material from a doctor or pharmacy?
- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Below this line is for Office Use:

Weight ____

Height ____

Blood Pressure ____

Vision Test: Left 20/ ___ Right 20/___

Hearing Test: Passed Failed

Please complete both sides of this form