CHILDREN FIRST
DUMFRIES PEDIATRICS

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:

_____

CONTINUES ON OTHER SIDE

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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?	Yes	No	

_____

_____

CONTINUES ON OTHER SIDE