



Well Child Check: 5 year visit questionnaire

Interval History:

Has your child had any major illnesses, ER or Urgent Care trips since
your last appointment in the office? No Yes

Has your child had any reactions to vaccinations in the past? No Yes

School/Activities:

What grade level is your child in school? _____

What activities does your child participate in (music/arts/sports/other)? _____

Development:

Can your child catch a ball? Hop on one foot? Yes No

Can your child jump a short distance? Yes No

Does your child tell stories? Yes No

Is your child's speech clear (little/no difficulty understanding
what your child says)? Yes No

Can your child write his or her name? Yes No

Can your child cut (with safety scissors) and paste? Yes No

Does your child enjoy playing with several children, have friends? Yes No

Is your child doing grade-level work at school or preschool? Yes No

Is your child toilet trained daytime and nighttime? Yes No

Do you and your child read together daily? Yes No

Do you have any concerns about how your child hears or speaks? No Yes

Do you have any concerns about how your child sees? No Yes

Dental Health:

Do you help your child brush and floss his/her teeth daily? Yes No

Does your child have a dentist? Yes No

Does your child's primary water source contain fluoride? Yes No Unsure

If no, do you give your child a fluoride supplement? Yes No N/A

Staying Healthy/Safety/Tobacco Exposure:

Does your child watch TV, play video games or use a tablet
or smart phone more than 2 hours per day? No Yes

Does your home have a working smoke detector?	Yes	No	
Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	N/A
Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	
Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4' 9")?	Yes	No	
Do you and your child spend time near water (a swimming pool, river or lake)?	No	Yes	
If so, is your child always safely supervised?	Yes	No	N/A
Knows or learning or already know how to swim?	Yes	No	N/A
Do you use sunscreen when your child is outdoors?	Yes	No	
Does your child spend time in a home where a gun is kept?	No	Yes	Skip
If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun?	Yes	No	N/A
Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip
If so, is the weapon safely stored and inaccessible to your child?	Yes	No	N/A
Does your child wear a helmet when riding a bike, skateboard or scooter?	Yes	No	N/A
Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	
Has your child been hit, or hit someone in the past year, other than occasional sibling or friend roughness?	No	Yes	
Has your child ever been bullied or felt unsafe at school or in your neighborhood?	No	Yes	
Does your child often seem sad or depressed?	No	Yes	
Does your child spend time with anyone who smokes?	No	Yes	

Risk Assessment for Lead Exposure:

Does your child live in or regularly visit a house or child care facility built before 1950?	No	Yes	
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)?	No	Yes	
Does your child have a sibling or playmate who has or did have lead poisoning?	No	Yes	

Does your child take any imported remedies or supplements? No Yes

Tuberculosis Screening:

Was your child born in a country with an elevated TB rate? No Yes
 This includes all countries *other than* the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.

Has your child visited or lived in a country with an elevated TB rate *for one month or more*? (Countries other than those listed above) No Yes

Has your child had contact with someone (including family member, childcare provider, or other caretaker) with known TB infection, or who has been treated for TB infection? No Yes Unsure

Is your child immunosuppressed (currently or planned)? No Yes
 This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

Sleep:

How many hours does your child sleep at night? _____ hours

Are you satisfied with your child's sleep? Yes No

Nutrition/Physical Activity:

What type of milk do you give your child? (circle one) [Whole] [2%] [Nonfat] [Other] [None]

How many ounces of milk does your child drink per day? _____ oz

How much juice does your child drink in 24 hours? _____ oz

Is your child eating fruits and vegetables at least two times per day? Yes No

Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, soy milk, cheese, yogurt, or tofu? Yes No

Does your child eat junk foods such as chips, fries, ice cream or fast food more than twice per week? No Yes

Does your child drink soda, sports drinks, energy drinks or other sweetened drinks more than once per week? No Yes

Does your child eat iron rich foods (such as meat, eggs, iron-fortified cereals or beans)? Yes No

Do you have trouble affording to buy food for your family? No Yes

Does your child exercise or play sports most days of the week? Yes No

Do you have any concerns about your child's weight or diet? No Yes

Elimination:

Does your child have bowel movements on a regular basis with
a normal (soft) consistency?

Yes No

Please list any medications or supplements your child is taking: _____

Who lives in the home with your child? _____

Who provides daytime care for your child? _____

Please list any new major family medical issues: _____

Please list any known allergies to medicines: _____

Please list any known food allergies: _____

Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider? _____

Parent or Guardian Signature: _____

Date: _____

<i>Clinic Use Only</i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined the SHA
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature		Print Name:		Date:	