4-5 YEAR OLD

www.pedsnw.net

NAME ______________________________
DATE ______________________________

MEDICAL HISTORY

Has your child had any reactions to medications or immunizations?
Does your child take any medications (daily or as needed)?
Is your child currently taking any vitamins, supplements, "alternative medicines" or therapies?
Are there any major illnesses in the family? Which ones? _________
Are there any major changes or stresses in the family (moves, deaths, separation, etc)?
Does your child attend day care or preschool? Where? ________________________
Has your child ever been diagnosed with an immunodeficiency?
Has your child had any illnesses, hospitalizations, or surgeries that we are not already aware of?

NUTRITION

Does your child get at least 4-5 servings of fruits/vegetables each day?
Does your child get at least 2-3 servings of calcium each day? (milk, cheese, yogurt or calcium supplements)?
Does your child drink anything other than milk and water?
_________ How many times per week does your child eat fast food?

PREVENTIVE HEALTH

Has your child seen a dentist in the past 6 months?
Does your child always ride in a car seat and in the backseat?
Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?
Have those alarms been checked in the past 12 months?
If you own firearms, are they always locked up?
Does your child live with anyone who smokes?
Has your child had close contact with anyone who has tuberculosis (TB), or is at high risk for TB (anyone who has lived in a developing country, been institutionalized, homeless, IV drug user, HIV positive)?
_________ How many hours of "screen time" (TV, movies, video games etc) is your child around per day?

REVIEW OF SYSTEMS *(Does your child have any **CURRENT** problems with the following?)*

headaches, fainting, dizziness, any loss of consciousness, or history of concussion
eyes (crossing, poor vision, etc)
ears, hearing, nosebleeds, or snoring disrupting sleep
coughing, breathing, shortness of breath, wheezing, limited endurance or chest pain
frequent stomachaches, vomiting, diarrhea, constipation, or any blood in the stools
urination (change in frequency, or blood in the urine)
coordination or extremities (feet, legs, arms, hands)
Has your child received blood, plasma, respigam, or gammaglobulin?

DEVELOPMENT (please check the things that your child is currently doing)

Gross motor	kicks a ball	jumps	hops on one foot	rides a tricycle
Fine motor	stacks blocks	scribbles	draws circle and cross	can cut and paste
Language	speech understandable	names 3 colors	counts 1-5	knows first & last name

VISION/ HEARING VISION/ HEARING

Per recommendations by the American Academy of Pediatrics (AAP), our providers will routinely order a vision screen and a hearing screen unless your child had one within the past 12 months. These are separate charges in addition to the Well Child visit charge. A few insurance plans do not cover hearing and vision screenings. We strongly recommend that you review your insurance plans coverage prior to your appointment.

If your child has had a hearing or vision screen in the past 12 months, please indicate below:
Recent Hearing Screen Date _________________ Recent Vision Screen Date _____________
____I prefer that my child NOT receive a Hearing or Vision screen today. (Please select one or both)

CONCERNS: Do you have any special concerns today? _______________

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Thanks for filling out this form.