

4-5 YEAR OLD

Patient Name: _____

Person Filling Out Form: _____

Relationship to Patient: _____



CONCERNS

yes no Do you have any questions or concerns about your child's health, development, or behavior?

MEDICAL HISTORY

- yes no Does your child take any medications (daily or as needed)? If so, please list: _____
- yes no Has your child had any reactions to medications?
- yes no Is your child currently taking any vitamins, supplements, "alternative medicines", or therapies?
- yes no Are there any major changes or stresses in the family (moves, deaths, separation, etc.)?
- yes no Does your child attend day care or preschool? Where? _____
- yes no Has your child had any new illnesses, ER visits, hospitalizations, or surgeries since their last visit?
- yes no Has a parent or household member ever had a problem with alcohol or drug use?
- yes no Is there any new information to add to family medical history since the last well child visit?

NUTRITION

- yes no Does your child get at least 4-5 servings of fruits/vegetables each day?
- yes no Does your child get at least 2-3 servings of calcium each day? (milk, cheese, yogurt or calcium supplements)?
- yes no Does your child drink anything other than milk and water? If so, what? _____
- _____ How many times per week does your child eat fast food?
- _____ How many times per week does your family eat meals together?

PREVENTIVE HEALTH

- yes no Has your child seen a dentist in the past 6 months?
 - yes no Do you help your child brush their teeth twice daily?
 - yes no Does your child always ride in a car seat and in the backseat?
 - yes no Does your child sleep 10-12 hours per night?
 - yes no Is your child watching more than 2 hours of screen time per day (TV, tablet, phone, movies, video games, etc.)?
 - yes no Does your child have outdoor time daily?
 - yes no Does your child use a helmet when using a bike or scooter or in a motorized toy?
 - yes no Does your child live with anyone who smokes, vapes, or uses e-cigarettes?
 - yes no Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?
 - yes no Have those alarms been checked in the past 12 months?
 - yes no N/A If you own firearms, are they always locked up and ammunition stored separately?
 - yes no Has a family member or close contact had tuberculosis or had a positive test for tuberculosis?
 - yes no Was your child born in or traveled to a country for more than a week that may have a higher risk of tuberculosis and had contact with the resident population (countries outside the United States, Canada, Australia, New Zealand, or Western European countries)?
 - yes no Is your child enrolled in WIC?
- On average, how difficult was it for your family to meet expenses for basic needs like food, housing, and/or utilities in the past year? (Please circle one that most applies):
- Never Seldom Some of the time Most of the time

REVIEW OF SYSTEMS (CIRCLE ANY CURRENT CONCERNS YOU WOULD LIKE TO DISCUSS TODAY)

- yes no Headaches
- yes no Eyes (crossing, poor vision, etc.)
- yes no Ears, hearing, nosebleeds, or snoring disrupting sleep
- yes no Coughing, breathing, shortness of breath, wheezing, limited endurance, or chest pain
- yes no Frequent stomachaches, vomiting, diarrhea, constipation, or any blood in the stools
- yes no Urination (change in frequency, or blood in urine)
- yes no Coordination or extremities (feet, legs, arms, hands)

Please continue on the other side.

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

Gross motor	<input type="checkbox"/> Kicks a ball	<input type="checkbox"/> Jumps	<input type="checkbox"/> Hops on one foot	<input type="checkbox"/> Rides a tricycle
Fine motor	<input type="checkbox"/> Stacks blocks	<input type="checkbox"/> Scribbles	<input type="checkbox"/> Draws circle and cross	<input type="checkbox"/> Can cut and paste
Language	<input type="checkbox"/> Speech understandable	<input type="checkbox"/> Counts 1-5	<input type="checkbox"/> Knows first & last name	

VISION/ HEARING

I i s in isi n s n in s 1 n s s in i
R n H in S n D R n Visi n S n D

Thank you for filling out this form.

Revised 6/2021