Patient Name:

Date of Birth:

Well Child Check: 5 year visit questionnaire

Interval History:

Has your child had any major illnesses or doctor visits since last seen here? No Yes

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

Development: Can your child (check all that apply) –

_ catch a ball? _ hop on one foot? _ jump a short distance? _ draw a triangle? _ draw a person?

_ write their name? _ cut with safety scissors? _ color? _ play well with others?

_ speak clearly? _ tell stories? _ stay dry all day and night?

Do you and your child read together daily? Yes No

School/Activities:

What grade level is your child in school? _________________ Where? ______________________________

Other activities (music/arts/sports/other): ____

Nutrition/Elimination/Physical Activity/Sleep

What type of milk does your child drink? ________________________ How much per day? ________ cups

How much yogurt per day? ________________________ How much cheese per day? _______________________

What dietary restrictions does your child have, if any? ____

Is your child eating 4 servings per day of a variety of fruits and vegetables? Yes No

Does your child eat iron-rich foods (meat, iron-fortified cereal, or beans)? Yes No

How much juice or sweet beverages does your child drink in a day? ______ oz

Does your child eat junk/fast food more than twice per week? No Yes

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

Are there any problems with pooping or peeing? No Yes

Your child's medications/vitamins/supplements: ____

Dental Health:

Does your child see a dentist every 6 months? Yes No

Does your child (with your help) brush his/her teeth daily? Yes No

Sleep:

How long does your child sleep at night? ____ hours

Staying Healthy/Safety:

Does your child get screen time more than 1 hour per day? No Yes

Does your home have a working smoke detector? Yes No

Does your child use sun protection when outdoors? Yes No

Is your child always supervised when near water and learning to swim? Yes No

Is your child always in a car seat/booster seat in the back seat? Yes No

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Does your child wear a helmet when riding anything with wheels?	Yes	No	N/A
Has your child seriously injured anyone or been seriously injured by someone in the past year?	No	Yes	
Has your child bullied or been bullied at home/school/neighborhood?	No	Yes	
Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	
Are all guns stored in a gun safe or locked with ammunition separate from gun?	Yes	No	N/A
Does your baby spend time with anyone who smokes or vapes?	No	Yes	

Please list any new major family medical issues:

____

Who lives in the home with your child?

____

What international travel has your child had since their last well check? (where and how long)

____

What plans are there for international travel with your child in the next 12 months? (where and how long)

____

What concerns would you like to discuss today?

____