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

**Risk Assessment for Lead Exposure:**

<table>
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<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
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<tr>
<td>Does your child live in or regularly visit a house or child care facility built before 1950?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>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)?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Does your child have a sibling or playmate who has or did have lead poisoning?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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: ___________________