

Five Year Visit:

Please answer the following questions. It will help your doctor spend more time discussing those specific issues that concern you. Please fill out **BOTH SIDES**.

- | | | | |
|---|-----|----|--------|
| Can your child skip or jump? | Yes | No | Unsure |
| Can your child hold a crayon or pencil well? | Yes | No | Unsure |
| Can your child ride a bike? | Yes | No | Unsure |
| Can your child draw a person with face, body and limbs? | Yes | No | Unsure |
| Can you child draw letters or numbers? | Yes | No | Unsure |
| Does your child speak in full sentences? | Yes | No | Unsure |
| Does your child know at least 4 colors? | Yes | No | Unsure |
| Does your child recognize most letters? | Yes | No | Unsure |
| Does your child play cooperatively? | Yes | No | Unsure |
| Does your child engage in make-believe play? | Yes | No | Unsure |
| Can your child explain the use of a ball or shoe? | Yes | No | Unsure |

How many ounces of milk does your child drink in 24 hours? _____oz; whole lowfat nonfat

How many ounces of juice/soda does your child drink in 24 hours? _____oz

Does your child eat meat (such as fish, chicken, beef or pork)? Yes No Unsure

On a typical day, does your child have less than 2 hours of screen time?

(TV, videogames, computer, etc) Yes No Unsure

Is your child toilet trained for both day and night? Yes No Partially

Do you usually use sunscreen for your child when outdoors? Yes No Unsure

Does your child wear a helmet if he/she is riding a tricycle or bike? Yes No Sometimes

Does your child brush his own teeth? Yes No Unsure

Does your child see a dentist regularly? Yes No Unsure

Do you think your child will be ready for kindergarten? Yes No Unsure

Are there guns at your home, or any home your child regularly visits? Yes No Unsure

Does your child have access to a home pool? Yes No Unsure

PLEASE TURN OVER

Your Child's Name: _____

Do you have any other safety concerns at your home? Yes No Unsure

What are your concerns? _____

Who provides daytime care for your child? _____

Does your tap water contain fluoride? Yes No Unsure

Is your child on any medications or supplements, including vitamins? If so, please list below:

Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease? Yes No

Has a family member had a positive tuberculin skin test? Yes No

Was your child born in a high-risk country?
(Countries **other** than the United States, Canada,
Australia, New Zealand, or western European countries) Yes No

Has your child traveled to (or had contact with people
who live in) a high-risk country for more than one week?
(Countries **other** than the United States, Canada,
Australia, New Zealand, or western European countries) Yes No

Risk Assessment for abnormal lipid profile (such as high cholesterol):

Did any of your child's parents or grandparents have significant heart disease
at or before 55 years of age (had a heart attack, stroke,
angioplasty, angina, or bypass surgery)? Yes No Unsure

Do either of the child's parents have a cholesterol level of 240 or higher? Yes No Unsure

Cholesterol screening may also be considered in anyone who is overweight, doesn't get much exercise, or who has high blood pressure or diabetes.

Do you have any concerns about your child's development, or any
other concerns you would like to discuss with your provider? Yes No

If so, what are your concerns?