Sutter Health

Well Child Check: 5 Year Visit

Your Child's Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT ALL PAGES.

Please list all the medications, vitamins, inhalers or supplements your child is currently taking:

_____

Please list your child's medication or food allergies, if any: _____

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 your 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 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	Low-fat	Nonfat
Does your child usually drink more than 6 oz. of juice or sweetened drinks daily?	No	Yes	Unsure
Does your child eat meat (such as fish, chicken, beef, or pork)?	Yes	No	Unsure
Does your child typically watch MORE than 2 hours of TV/Computer/Video games, etc. daily?	No	Yes	Unsure
Is your child toilet trained for both day and night?	Yes	No	Partially
Do you usually protect your child with sunscreen/hats/ other measures when outdoors?	Yes	No	Unsure
Does your child wear a helmet when riding a tricycle or bike?	Yes	No	Sometimes
Does your child brush teeth at least two times daily?	Yes	No	Unsure
Does your child see a dentist at least once a year (every 6 months is best)?	Yes	No	Unsure
Does your water contain fluoride?	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?	No	Yes	Unsure
Does your child have access to a pool that does not have a locked gate?	No	Yes	Unsure
Do you have any other safety concerns at your home? If so, please describe:			

_____

Who provides daytime care for your child?

_____

****CONTINUE TO NEXT PAGE****

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RISK ASSESSMENT FOR LEAD EXPOSURE:

Does your child live in or regularly visit a house or childcare facility built before 1950?	No	Yes	Unsure
Does your child live in or regularly visit a house or childcare facility built before 1978 that is being or has recently been remodeled (within the last 6 months)?	No	Yes	Unsure
Does your child have a sibling or playmate who has or did have lead poisoning?	No	Yes	Unsure
Does your child use any imported medicines or supplements?	No	Yes	Unsure

RISK ASSESSMENT FOR TUBERCULOSIS EXPOSURE / INFECTION:

Was your child born outside of the United States? If so, where? _____	No	Yes	Unsure
Has your child ever spent more than a month in any country outside of the United States? If so, where? _____	No	Yes	Unsure
Is your child immunosuppressed – currently or planned?	No	Yes	Unsure
Has your child been in close contact with someone while they had active tuberculosis (TB)?	No	Yes	Unsure

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

Do you have any concerns about your child's development, or any other concerns you would like to discuss?

If so, please describe:

_____

_____