5 Year Pre-Visit Questionnaire

For us to provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all of the questions.

CHILD'S NAME:_________________________________ DATE OF BIRTH: ___________________

YOUR NAME: __________________________________ RELATIONSHIP: ____________________

Do you have any concerns, questions or problems that you would like to discuss today? Please describe:____
____
____

Does your child have any allergies? YES/NO If yes, please list:____________________________
Does your child take any medications? YES/NO If yes, please list:_________________________
Has your child seen any other healthcare providers? YES/NO If yes, please list: _____________

Have there been any recent changes in your family? (check all that apply)

_____ Death _____ Divorce Other: ________________________
_____ Job Change _____ Move ________________________

FEEDING/NUTRITION

Is your child drinking 2% milk? YES/NO If yes, how much in a day? ___________ounces
What else does your child eat?____
____

Review of Systems	Yes	No
Do you have concerns about how your child hears?		
Do you have concerns about how your child is talking?		
Do you have concerns about how your child sees?		
Do you have concerns about your child's development or behavior?		

Risk Assessment	Never	Sometimes	All the time
Does your child live with anyone who smokes or spend time in a place where people smoke?			
Has a family member's drinking or drug use ever had a bad effect on your child?			
In the past year did you ever worry that your food would run out before you got money to buy more?			

	Yes	No
Does your child live in or visit a house build before 1950?		
Does your child live in or visit a house built before 1978 that has been renovated in the past 6 months?		
Does your child have a sibling or playmate who has had lead poisoning?		
Does your child have a family member who participates in a lead related job or hobby (casting or soldering – bullets, fishing weights, stained glass)?		
Does your child have a family member who uses traditional folk medicines or cosmetics or routinely imports food from abroad?		
Does your child live near lead smelters, battery recycling plants or other industries that might release atmospheric lead?		

	Yes	No
Has a family member or contact had tb or had a + skin test?		
Was your child born in a country at high risk for tb (any country other than the US, Canada, Australia, New Zealand or Western Europe)?		
Has your child traveled to a country other than the US, Canada, Australia, New Zealand or Western Europe and stayed longer than a week?		

	Yes	No
Are cavities a problem for you or for anyone in your family?		
Does your child see a dentist at least twice a year?		

DEVELOPMENTAL MILESTONES: Please put a check beside the things your child is able to do.

_____ Balances on 1 foot
_____ Hops, skips, climbs
_____ Draws a person with 6 body parts
_____ Counts to 10
_____ Names 4 colors
_____ Copies a square and triangle
_____ Writes some letters and numbers
_____ Ties a knot
_____ Brushes own teeth
_____ Listens well and follows simple instructions