OBERLIN ROAD PEDIATRICS

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 BOTH SIDES.

Can your child skip or jump?	Yes	No	
Can your child hold a crayon or pencil well?	Yes	No	
Can your child ride a bike?	Yes	No	
Can your child draw a person with face, body and limbs?	Yes	No	
Can your child draw letters or numbers?	Yes	No	

Does your child speak in full sentences?	Yes	No	
Does your child know at least 4 colors?	Yes	No	
Does your child recognize most letters?	Yes	No	
Does your child engage in make-believe play?	Yes	No	
Can your child explain the use of a ball or shoe?	Yes	No	

How many ounces of milk does your child drink in 24 hours? _____oz.	Whole	2%	1%
Does your child usually drink more than 6 oz. of juice or sweetened drinks daily?	No	Yes	
Does your child eat meat (such as fish, chicken, beef, or pork)?	Yes	No	

Does your child typically watch MORE than 1 hour of TV / Computer / Video games, etc. daily?	No	Yes	
Is your child toilet trained for both day and night?	Yes	No	
Do you usually protect your child with sunscreen / hats / other measures when outdoors?	Yes	No	
Does your child wear a helmet if he is riding a tricycle or bike?	Yes	No	

Do you help your child brush his/her teeth twice a day?	Yes	No	
Does your child see a dentist at least once a year (every 6 months is best)?	Yes	No	
Does your tap water contain fluoride? City water contains fluoride.	Yes	No	

Do you or any immediate family members have a history of mental illness? No Yes

If yes, please explain: _____

_____

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

Does your child have access to a pool that does **NOT** have a locked gate? No Yes

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

If so, please describe: _____

_____

CONTINUES ON OTHER SIDE

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Who provides day time care for your child? _____

_____

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

_____

_____

_____

Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease?	No	Yes	
Since your child's last well check has a family member or contact had a positive tuberculosis test?	No	Yes	
Was your child born in a high-risk country (Countries other than the United States,Canada, Australia, New Zealand, or western European countries)?	No	Yes	
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)?	No	Yes	

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

If so, please describe? _____

_____

_____

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SOCIAL DETERMINANTS OF HEALTH

There are programs to help people with needs that can affect their health, but they aren't reaching everyone who may need them. Are there things you need help with?

Food

Within the past 12 months, did you worry that your food would run out before you got money to buy more?	No	Yes	
Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	No	Yes	

Interpersonal Safety

Do you feel physically or emotionally unsafe where you currently live?	No	Yes	
Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?	No	Yes	
Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	No	Yes	