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	Partially
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	Sometimes
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	
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? If so, please describe:

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:

CONTINUES ON OTHER SIDE

Well Child Check: 5 Year Visit

Risk Assessment for Tuberculosis Exposure:

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? If so, please describe?