5 Year Pre-Visit Questionnaire

Instructions: Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.

General Health

1. Do you have any concerns about your child's health?	NO	YES
2. Any problems with previous immunizations?	NO	YES

Feeding/Nutrition

3. Does your child have fruits or vegetables at every meal?	YES	NO
4. Do you give your child mostly whole grains?	YES	NO
5. Is your child drinking milk?	YES	NO
a. What type of milk?		
b. How much milk per day?		
6. Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods daily?	NO	YES
7. Does your child drink juice or other sweetened drinks?	NO	YES
8. Are you giving any vitamins or supplements?	YES	NO

Lipids

9. Parents/grandparents with stroke/heart attack before 55?	NO	YES
10. Parent with high cholesterol or on cholesterol medication?	NO	YES

Oral Health

11. Are cavities a problem for you or anyone in your family?	NO	YES
12. Brushing teeth twice a day, and flossing once a day?	YES	NO
13. Sees a dentist at least two times each year?	YES	NO
14. Does your child's water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

15. Child has a daily, soft bowel movement (poop)?	YES	NO

School

16. Is your child in school?	YES	NO
17. Any concerns about your child's learning or school behavior?	NO	YES

Activity/Exercise/Screen time

18. Does your child have more than 2 hours of screen time per day (TV, computer, video games)?	NO	YES
19. Is there a TV or video game system in child's bedroom?	NO	YES
20. Child plays actively at least one hour per day?	YES	NO
21. Do you read to your child every day?	YES	NO
22. Do you encourage activities such as walking, bicycling, swimming, or dancing?	YES	NO
23. Do you do educational activities as a family, such as go to museums, zoos, or libraries?	YES	NO
24. Do you eat meals together as a family?	YES	NO
25. Do you spend time alone with each of your children?	YES	NO
26. Do you spend time alone with your partner?	YES	NO

Sleep

27. Do you have concerns about your child's sleep?	NO	YES
28. Does your child snore more than a little?	NO	YES

Social Stressors

29. Are you able to take a little time for yourself?	YES	NO
30. Any major changes or stresses in your family recently?	NO	YES
31. Do you ever worry your family will go hungry?	NO	YES

Behavior

32. Questions about discipline?	NO	YES
33. Do you praise your child when he/she is behaving well?	YES	NO
34. Do you give your child choices?	YES	NO

Development

35. Talks well, using long meaningful sentences?	YES	NO
36. Tells simple stories and nursery rhymes?	YES	NO
37. Other people can fully understand child's speech?	YES	NO
38. Knows full name, telephone number, 911?	YES	NO
39. Creates imaginary stories, fantasies, situations?	YES	NO
40. Skips or hops on one foot 4-5 times?	YES	NO
41. Knows four or more colors?	YES	NO
42. Counts to ten?	YES	NO
43. Stacks eight or more blocks?	YES	NO
44. Can draw a person with head, body, arms, and legs?	YES	NO
45. Can draw a square?	YES	NO
46. Dresses self without supervision?	YES	NO

Safety

47. Do you talk to your child about stranger safety?	YES	NO
48. Does your child know that private parts are private?	YES	NO
49. Do you watch your child when he plays outside?	YES	NO
50. Child wears a helmet when biking, skating, skiing or snowboarding?	YES	NO
51. Is child exposed to anyone who smokes?	NO	YES
52. Is there a gun in the home? a. Is it locked or in a safe?	NO	YES
53. Child rides in a safety seat, in the back seat?	YES	NO
54. Applying sunscreen when outside for a long time?	YES	NO
55. Do you ever leave your child alone in car, house, or yard?	NO	YES
56. Working smoke detectors and carbon monoxide detectors?	YES	NO
57. Do you have a home fire escape plan?	YES	NO

Tuberculosis

58. Has a family member or contact had tuberculosis	NO	YES
59. Has a family member had a positive TB skin test (PPD)?	NO	YES
60. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
61. Has your child traveled to a high-risk country for more than a week?	NO	YES

Review of Systems

*Any **Concerns** about...*		
62. Vision?	NO	YES

63. Hearing?	NO	YES
64. Allergies?	NO	YES
65. Wheezing?	NO	YES
66. Frequent abdominal pain?	NO	YES
67. Frequent joint pains?	NO	YES
68. Headaches?	NO	YES
69. Skin or rashes?	NO	YES