UW Medicine
UW NEIGHBORHOOD CLINICS

5 Year Old Well Child Visit

Child's Name _____ Child's Birth Date _____

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Review of Nutrition	**Yes**	**No**
Does she/he eat well-balanced diet, including fruits, vegetables, milk, and vitamins?	( )	( )
Does your child see a dentist twice a year?	( )	( )
Do you help your child brush her/his teeth 2 times daily?	( )	( )
Do you help your child floss her/his teeth once daily?	( )	( )

Elimination	**Yes**	**No**
Is your child stooling comfortably?	( )	( )
Is she/he toilet trained, day and night?	( )	( )

Sleep	**Yes**	**No**
Is your child sleeping well, without snoring often?	( )	( )

Social Screening	**Yes**	**No**
Are things going well overall for your family?	( )	( )
Is your home smoke-free? (choose "No" even if smoking is outside)	( )	( )
Does your child get regular exercise?	( )	( )
Does your child have a booster seat in the car?	( )	( )
Are you happy with your child's behavior overall?	( )	( )
Do you read with your child 3 or more times per week?	( )	( )
Does your child get along well with other children?	( )	( )
Is school going well?	( )	( )
Is screen time (TV, video games, computer) limited to <2 hours per day?	( )	( )
Tuberculosis (TB) risk?		
1. Contact with person who has tuberculosis	( )	( )
2. Your child is immuno-suppressed (HIV, cancer, chronic steroids)	( )	( )
3. Birth or travel to endemic Tuberculosis areas (Africa, Asia, Latin America, Caribbean)	( )	( )
4. Regular contact with adults at high risk for TB (Homeless, Jailed, Illegal drug user, HIV positive person, migrant farm worker, nursing home resident)	( )	( )

Developmental Screening	**Yes**	**No**
Can dress self without help?	( )	( )
Can count to 10 or higher?	( )	( )
Uses complete sentences?	( )	( )
Can your child tell a simple story?	( )	( )
Recognizes most letters of the alphabet?	( )	( )
Goes up and down stairs, alternating feet, without holding railing?	( )	( )
Use the back of this paper for the next 4 questions		
Copies a triangle or a square?	( )	( )
Can draw a person with at least a head, body, arms and legs?	( )	( )
Can write some letters?	( )	( )
Can write his/her name?	( )	( )

Has your child had any significant illnesses since the last time we saw you? If yes, please describe:

_____

Are there any new stresses on your family since the last time we saw you? If yes, please describe:

_____

Current concerns not listed above:

_____