



PATIENT NAME: _____

DATE: ____ / ____ / ____

Questions for 5 year visit

Please complete the following questions as they apply to your child.

NUTRITION

Is your child drinking milk? yes no

If yes, what type?

whole 1% 2% skim soy rice

If yes, how much milk does your child drink per day?

< 8 oz 8 to 16 oz 16 to 24 oz 24 to 32 oz > 32 oz

How much juice, Gatorade, sports drinks, and soda pop does your child drink per day?

0 to 4 oz 4 to 8 oz 8 to 16 oz > 16 oz

How much water does your child drink per day?

< 8 oz 8 to 16 oz 16 to 24 oz > 24 oz

Your child has what type of water source?

city well bottled with fluoride bottled without fluoride

How many scheduled meals is your child offered per day?

1 to 2 2 to 3 3 to 4 > 4

How many snacks is your child offered per day?

none 1 1 to 2 > 2

Has your child eliminated any main food groups from his/her diet?

meats vegetables fruits grains/breads

ELIMINATION

How frequently does your child have a bowel movement?

> every 4 days every 3 to 4 days every other day every day
 1 to 2 times per day > 2 times per day

Is your child having any problems with his/her bowel movements? yes no

If yes, please explain. _____

Is your child having any problems with his/her urination? yes no

If yes, please explain. _____

SLEEP

Does your child have a fairly consistent bedtime? yes no

How many hours does your child sleep at night?

< 8 8 to 10 10 to 12 > 12

How many naps does your child take during the day?

none 1 > 1

Does your child have any problems with his/her sleep?

snoring restless sleep paused or startled breathing difficulty falling asleep night terrors
 poor sleep quality (being tired after sleeping) frequent nighttime awakenings nightmares teeth grinding
 other: _____

VISION

Do you have any concerns regarding your child's vision? yes no

If yes, what? _____

HEARING

Do you have any concerns regarding your child's hearing? yes no

If yes, what? _____

SOCIAL AND PRESCHOOL/SCHOOL DEVELOPMENT

Does your child play well with other children? yes no

Does your child get along with others at preschool/school? yes no evolving n/a

Is your child adjusting well to preschool/school/home schooling? yes no evolving n/a

(Please circle the appropriate school setting in addition to answering the question.)

What activities does your child enjoy outside of school?

sports bicycling exercise art using a computer

videogames watching TV watching movies reading

other: _____

PERSONAL HABITS

Does your child use a computer in your home? yes no

If yes, where is the computer located?

the child's bedroom a secondary bedroom the office the family room

the living room the kitchen is portable

How much TV does your child watch per day?

none < 30 minutes per day < 1 hour per day 1 to 2 hours per day > 2 hours per day

How much time does your child spend playing video games per day?

none < 30 minutes < 1 hour 1 to 2 hours > 2 hours

DEVELOPMENT

Can button some of his/her own clothing or his/her doll's clothing (Snaps do not count) yes no

Reacts well when left with a friend or a sitter yes no

Can name at least three colors yes no

Can walk up and down stairs alternating his/her feet yes no

Can jump with his/her feet apart (broad jump) yes no

Can point while counting at least three different objects yes no

Can name a coin correctly yes no

Likes to relax with you for 10-20 minutes of story time yes no

Can copy a square yes no

Can name at least some of the letters of the alphabet when he/she sees them yes no

Can identify and print the first letter in his/her name yes no

Can recognize and name several single numbers yes no

Can recognize common street and store signs (eg, "Stop" "Open") yes no

SAFETY

What type of car seat does your child use?

a 5 point (forward facing) toddler (convertible) seat in the back seat of the vehicle

a (forward facing) booster seat in the back seat of the vehicle other: _____

Do you have a pool? yes no

If yes, what type?

above ground without a fence

in ground without a fence

above ground with a fence around the pool

above ground with a fence around the yard in ground with a fence around the pool in ground with a fence around the yard

J.A.N. 27.2010 Signature of Provider _____ Date: ____ / ____ / ____



PATIENT NAME: _____

PROVIDER: _____ DATE: ____/____/____ ZIP CODE: _____

Lead Screening

A documented result of a blood lead test or a properly filled out Childhood Lead Risk Assessment Questionnaire must be attached to a Certificate of Child Health Examination form for purposes of admission to an Illinois Department of Children and Family Services or state regulated child-care facility, including those operated by a school district.

Respond to the following questions by checking the appropriate answer.

- | | |
|--|---|
| Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Does this child have a sibling with a blood lead level of 10 mcg/dL or higher? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Does this child live in or regularly visit a home that was built before 1978? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Is this child a refugee or an adoptee from any foreign country? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

M.A.R. 5.2010 Signature of Provider _____ Date: ____/____/____



PATIENT NAME: _____ AGE: _____

PROVIDER: _____ DATE: ____/____/____

Tuberculosis Screening

In order to determine whether or not a TB test is indicated for your child, we need you to answer the following questions. Because exposure risks can change, we will ask you to update this questionnaire at the 6, 12, 18, and 24 month well child visits and then annually until 21 years of age.

Respond to the following questions by checking the appropriate answer.

- | | |
|---|---|
| Has a member of your family or a person who has contact with your child and tuberculosis disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Has a family member had a positive tuberculin skin (TB) test? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Was your child born in a country with a high rate of tuberculosis (places other than the United States, Canada, Australia, New Zealand, or Western European countries) like Mexico, South and Central America, Asia, India, and Eastern European countries? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Has your child traveled (had contact with resident populations) to a high risk country for more than 1 week? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

M.A.R. 5.2010 Signature of Provider _____ Date: ____ / ____ / ____