



ABC Pediatrics

5 Year Pre-visit Questionnaire

Patient Name _____

Date _____

Bathes: (daily) (every other day)

Interacts well with family? _____ Interacts well with friends? _____

Diet

Balanced Diet? _____ Picky eater? _____ Cups of milk daily _____

Problems with constipation? _____ Bed wetting? _____ # of hours sleeping at ONE time _____

Is there any secondhand smoke exposure in your home or car? _____

Attends school@ _____ Grades are: Above Average Average Below Average

Developmental Milestones (check all that apply):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Copies a shape | <input type="checkbox"/> Dresses themselves | <input type="checkbox"/> Draws a person with 6 parts | <input type="checkbox"/> Hops on 1 foot |
| <input type="checkbox"/> Opposite Analogies | <input type="checkbox"/> Knows 4 colors | <input type="checkbox"/> Ties shoelaces | <input type="checkbox"/> Uses Scissors |
| <input type="checkbox"/> Comprehends tired, cold, and hungry | <input type="checkbox"/> Defines some words | <input type="checkbox"/> Comprehends prepositions | <input type="checkbox"/> Engages in role play |
| <input type="checkbox"/> Interacts with peers | <input type="checkbox"/> Picks longer of 3 lines | <input type="checkbox"/> Uses scissors | <input type="checkbox"/> Understands and follows directions |

TB Screen	Has a family member or contact been diagnosed with TB?	YES	NO
	Was your child born in a country at high risk for TB?	YES	NO
	Has your child traveled to a country at high risk for TB?	YES	NO
Lead Risk	Does your child have a sibling or playmate that has had lead poisoning?	YES	NO
	Does your child live in or regularly visit a home built before 1978 that being renovated?	YES	NO
	Does your child live in or regularly visit a house or childcare facility built before 1950?	YES	NO

Are there any other concerns you would like to discuss? _____

Wt _____ Ht _____ BP _____ P _____ T _____ Vision _____ Hearing _____