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? _____

Type of water (bottled/well/city): _____ # 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

Current Dentist: _____

Developmental Milestones (check all that apply):

• Tells a story of 2 sentences or more.	• Spreads with a knife	• Answer why questions	• Writes 2 or more letters
• Follows directions for 4 individual prepositions.	• Dresses and undresses without help	• Copies a triangle	• Is beginning to skip
• Counts 5 objects	• Goes to the bathroom independently	• Draws a 6- part person	• Walks on tiptoes when asked
• Names 4 or more letters out of order	• Plays and interacts with peers	• Cuts well with scissors	

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_____