ABC Pediatrics

5-6 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):

- ☐ Copies a shape
- ☐ Dresses themselves
- ☐ Draws a person with 6 parts
- ☐ Hops on 1 foot
- ☐ Opposite Analogies
- ☐ Knows 4 colors
- ☐ Ties shoelaces
- ☐ Comprehends tired, cold, and hungry
- ☐ Defines some words
- ☐ Comprehends prepositions
- ☐ Engages in role play
- ☐ Interacts with peers
- ☐ Picks longer of 3 lines
- ☐ Uses scissors
- ☐ 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? ____________________________________

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Wt ______ Ht ______ BP_______ P _______ T ________ Vision_______ Hearing________