UW Medicine
UW NEIGHBORHOOD CLINICS

5 Year Old Well Child Visit

Child's Name _____ Child's Age _____ Date _____

Person completing the form _____ Relationship to the patient _____

Has your child had any illnesses, hospitalizations or surgeries since last visit here? (YES) (NO)

Review of Nutrition:	Yes	No
Is your child drinking low-fat milk, limited to no more than 2-3 cups per day?	( )	( )
Is juice/sugary drinks limited to 0-1 servings per day?	( )	( )
Does your child eat a variety of fruits/vegetable/meat?	( )	( )
Does your child take a supplement that contains Vitamin D regularly?	( )	( )
On average, does your child eat fast food one or more timed per week?	( )	( )

Family and Social History:	Yes	No
Are there any major illnesses in the family that we are not already aware of?	( )	( )
Are there any major stressors in the family (illnesses, moves, death or separation)?	( )	( )

Preventative Health/Risk Factors:	Yes	No
Is screen time (TV/video games/computer/tablet/phone limited to less than 2 hours per day?	( )	( )
Does your child always ride in a car seat in the back seat?	( )	( )
Do you, anyone who cares for your child or anyone in the home smoke?	( )	( )
Does your child wear a helmet when riding a bike, skateboarding, rollerblading etc?	( )	( )
Are there any guns in the home? And if so, are they always empty and locked?	( )	( )
Are there smoke detectors and fire extinguishers at home and are they checked yearly?	( )	( )
Has your child had close contact with anyone who has tuberculosis (TB) or is at high risk for TB (visited Africa, Latin American, Caribbean country, been homeless, or jailed, IV drug user, HIV positive)?	( )	( )
Does your child see the dentist twice a year and brush teeth daily?	( )	( )
Does your child have at least 1 hour of active play daily?	( )	( )

Behavioral/Mental Health:	Yes	No
Does your child have a regular sleep routine?	( )	( )
Does your child sleep well without snoring?	( )	( )
Does your child wet the bed regularly?	( )	( )
Do you have any concerns about how your child is learning, developing and behaving?	( )	( )
Are you interested in enrolling your child in Head Start/preschool? If so, do you need assistance with this?	( )	( )

Developmental Surveillance:	Yes	No
Motor:		
Balances on 1 foot?	( )	( )
Hops and skips?	( )	( )
Able to tie a knot?	( )	( )

	Yes	No
Language:		
Can tell a story with full sentence?	( )	( )

	Yes	No
Learning:	( )	( )
Draws person (6+ body parts)?	( )	( )
Prints some letters and numbers?	( )	( )
Copies squares, triangles?	( )	( )
Counts to 10?	( )	( )
Names 4 or more colors?	( )	( )
Follows simple directions?	( )	( )
Listens?	( )	( )