UW Medicine
PRIMARY CARE

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)

Nutrition:	**Yes**	**No**
Is your child drinking low-fat milk, limited to no more than 2-3 cups per day?	( )	( )
Is juice or sugary drinks limited to 0-1 servings per day?	( )	( )
Does your child eat a variety of fruits/vegetables/dairy/meat?	( )	( )
Does your child regularly take a supplement that contains vitamin D?	( )	( )
On average, does your child eat fast food one or more times 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 (illness, moves, death, separation)?	( )	( )

Preventative Health/Risk Factors:	**Yes**	**No**
Is screen time (TV/videos/video games/computer/tablet/phone) limited to less than 2 hours a 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 your home smoke?	( )	( )
Does your child wear a helmet when riding a bike, skateboarding, rollerblading, etc.?	( )	( )
Are there any guns in the home? • If yes, are they always kept empty and locked?	( ) ( )	( ) ( )
Are there smoke detectors and fire extinguishers in the home? • 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, Asia, Latin America, Caribbean Country, been homeless or jailed, IV user, HIV positive)?	( )	( )
Does your child have at least one hour of active play per day?	( )	( )

Oral Health:	**Yes**	**No**
Does your child see a dentist twice a year and brush teeth 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 or preschool?	( )	( )
• If yes, do you need assistance to find a suitable program?	( )	( )

Developmental Surveillance:

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

Language Skills:	**Yes**	**No**
Can tell a story with full sentences?	( )	( )

Learning Skills:	**Yes**	**No**
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?	( )	( )