OBERLIN ROAD PEDIATRICS

Well Child Check: 5 Year Visit

Your Child's Name: _____

Do you have any concerns about your child's behavior, learning, or development? If yes, please describe:

_____

_____

Does your child take any medications or supplements, including vitamins? If yes, please list. □ No □ Yes: _____

Does your child have known allergies to foods/medicines? If yes, please list. □ No □ Yes: _____

Does your child see any specialists outside of Oberlin? □ No □ Yes: _____

Dental Health:

Does your child see a dentist 1-2 times a year? □ Yes □ No

Does your water source contain fluoride? □ Yes (=city water) □ No (=well water)

Are you brushing your child's teeth with fluoridated toothpaste 2x a day? □ Yes □ No

Tuberculosis screen:

Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test? □ No □ Yes

Was your child or any household member born in or traveled to a high-risk country? (This includes countries in Africa, Asia, Latin America, and Eastern Europe)? □ No □Yes

Nutrition:

Are they usually getting 3 servings of dairy a day (8 oz milk=1 serving)? □ Yes □ No

Are they usually drinking MORE than 24 oz of milk a day? □ No □ Yes

What type of milk is your child drinking? □ Whole Milk □ 2% □ 1% □ other _____

Are they eating iron-rich foods daily (meat, beans, enriched cereals/cheerios)? □ Yes □ No

Developmental Questions: Does your child..?

Follow rules or take turns when playing games with other children?	Yes	No
Sing, dance or act for you?	Yes	No
Do simple chores at home like matching socks or clearing the table?	Yes	No
Tell a story they heard or made up with at least 2 events?	Yes	No
Answer simple questions about a book or story after you read or tell it to them?	Yes	No
Keep a conversation going with >3 back and forth exchanges?	Yes	No
Speak clearly so that a stranger would understand them?	Yes	No
Count to 10?	Yes	No
Name some numbers between 1 and 5 when you point to the digit?	Yes	No
Recognize and use simple rhymes?	Yes	No
Use words about time, like yesterday, tomorrow, morning or night?	Yes	No
Pay attention for 5-10 min during activities, for example, during story time or making crafts? (screen time does not count)	Yes	No
Write some letters in their name?	Yes	No
Name some letters when you point to them?	Yes	No
Button some buttons?	Yes	No
Hop on 1 foot?	Yes	No

Who takes care of your child during the day? _____

Are parents: single married divorced separated widowed

Have there been major changes lately in your child's or family's life? _____

Is your child generally happy and active?	Yes	No
Does your child have chores and responsibilities at home?	Yes	No
Does your family get along well with each other?	Yes	No
Do you let your child know when they are being good?	Yes	No
Does your child have unusual problems dealing with angry feelings?	No	Yes
Does your child play Ok with other children?	Yes	No
Does your child play actively for at least 1 hour a day?	Yes	No
How much time every day does your child spend watching devices/screens?	_____	
Does your child have a TV/screen in their bedroom?	No	Yes
Are you happy with your child's sleep?	Yes	No
Does your child have a regular bedtime?	Yes	No
Is your child always in the car seat in the back seat of the car?	Yes	No
Does your child wear a helmet when biking, skating, or scootering?	Yes	No
Can your child swim?	Yes	No
Does your child wear sunscreen?	Yes	No
Do you offer your child at least 5 servings of vegetables or fruits a day?	Yes	No
Do you let your child decide what to eat and how much?	Yes	No
Does your child drink sugar sweetened beverages: juice/soda/sports drinks daily?	No	Yes
Do you have smoke alarms and carbon monoxide alarms in your house?	Yes	No
Does your child spend time in a place with an unlocked gun?	No	Yes
Do you feel safe in your home and community?	Yes	No
Has your partner or another significant person in your life ever hurt you or your child?	No	Yes
Do you have the things you need to take care of your child?	Yes	No
Does your home have enough heat/AC, hot water, electricity?	Yes	No
Within the past 12 months, were you ever worried whether your food would run out?	No	Yes
Is there anyone in your child's life whose alcohol/drug use concerns you?	No	Yes
Do you discuss with your child that no one should see their private parts or keep secrets from their parents?	Yes	No