4-5 Year Visit

Pt. Name_____ DOB_____

THIS SECTION TO BE COMPLETED BY PARENT

Personal Social History

Are you concerned about your child's...(circle concerns)	**Yes**	**No**
1. Eating habits, weight loss, ↓ energy, sleep habits……	☐	☐
2. Redness, excessive tearing or discharge from eyes……	☐	☐
3. Recurrent ear, sinus or throat infections; nose bleeds …..……..	☐	☐
4. Chest pain, shortness of breath or irregular heart beat……	☐	☐
5. Frequent colds, cough, wheezing, recurrent bronchitis…..……	☐	☐
6. Abdominal pain, vomiting, diarrhea, constipation ……	☐	☐
7. Urinary control, bed wetting, urinary infections……..…	☐	☐
8. Joint pain, stiffness, swelling: muscle pain weakness……	☐	☐
9. Birthmarks, skin rashes, itching, nail or hair problems……..	☐	☐
10. Recurrent headaches, dizziness, tics, weakness, seizures…….	☐	☐
11. Mood changes, sadness, nervous problems…….	☐	☐
12. Excessive thirst or hunger, ↑ urination, weight loss…….	☐	☐
13. Paleness, anemia, easy bruising, swollen glands……	☐	☐
14. Milk, food or drug allergies, recurrent infections……..	☐	☐
Does your child...		
15. Talk well, using long meaningful sentences ……...……..	☐	☐
16. Tell simple stories and nursery rhymes…….……	☐	☐
17. Watch television program 20-30 minutes……	☐	☐
18. Know full name, address, telephone number, 911…...……	☐	☐
19. Understand 2-3 step instructions…….……	☐	☐
20. Sing simples songs…….……...……	☐	☐
21. Create imaginary stories, fantasies, situations..…..……..	☐	☐
22. Skip or hop on one foot 4-5 times…...……...……..	☐	☐
23. Run on tiptoes…….……...……	☐	☐
24. Stack 10 or more blocks…….……	☐	☐
25. Use crayons or scissors well……	☐	☐
26. Draw a person with a head, body, arms and legs……..…	☐	☐
27. Dress self without supervision……..…	☐	☐
28. Does your child take a nap or rest during the day……	☐	☐
28. Does he/she separate from you without difficulty……...	☐	☐
29. Does your child use a safety seat/belt and ride in the back seat?	☐	☐
30. Has your child had any problems in preschool?……	☐	☐
31. Has your child had any problems listening or sitting still?……	☐	☐
32. Do you have any concerns about development or behavior?….	☐	☐
33. Do you have any concerns about school readiness?…….	☐	☐
34. Does anyone have a gun in the home?…….	☐	☐

Lead Screen

Does your child...		
1. Live in or regularly visit a house that was built before 1950? (day care, baby sitter or relative)……...	☐	☐
2. Live in or regularly visit a house built before 1978 with recent or ongoing renovations or remodeling (w/in the last 6 months)…	☐	☐
3. Have a sibling or playmate who now had or did have lead poisoning?……	☐	☐

Do you have any concerns you wish to discuss?……..

☐_____

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