Patient ID_____ Patients Name_____

PCP_____ DOB_____

Today's Date_____

5 Year Old Parent Observations

Are there any concerns you would like to discuss today?_____

_____

Activities/interests:

List any extracurricular activities (i.e. a sport, dance): _____

List any interests (i.e. instrument, art, playing outside): _____

How much screen time (TV/tablet/phone) does your child have per day? _____

Diet/Sleep:

Does your child eat well (i.e. has consistent appetite, not too picky)? Yes No

What does your child drink?_____

If picky, what does your child dislike? _____

Any concerns about voiding or stooling? (i.e. constipation, bedwetting) Yes No

Is your child potty trained: (check all that apply) ☐ Day ☐ Night ☐Urine ☐ Stool

Does your child have any problems with sleep? Yes No

Development:

Do you have any concerns about your child's hearing or vision? Yes No

Any concerns about your child's development? Yes No

Does your child: (please check all that apply)

☐ draw a square	☐ use complete sentences	☐ know first/last name
☐ write name	☐ use tenses or pronouns	☐ count to 10
☐ catch a ball	☐ speech is 100% understandable	☐ follow rules

Social/Behavior:

Has your child attended preschool? Yes No If yes, did he/she like it/do well? Yes No

Are there any family or social issues you would like to discuss? Yes No

Any concerns about your child's behavior (i.e. tantrums, socializing)? Yes No

Safety/Preventative Health:

Does your child use a car seat or booster 100% of the time? Yes No

Is your home/car a smoke-free environment? Yes No

Does your child brush his/her teeth with a fluoride toothpaste? Yes No

Has your child seen a dentist in the last 6 months? Yes No

Does your child participate in regular physical activity? (about 1 hr play/sport) Yes No

Does your child always wear a helmet when riding bike/scooter/skiing/etc? Yes No

Have you discussed "stranger danger" with your child? Yes No

Have you discussed trampoline/water safety with your child? Yes No

Do you own a gun? Yes No If yes, is it stored safely (i.e. locked case)? Yes No

Are your child's immunizations up to date? Yes No

Does your child have any allergies (that you know of)? Yes No

Please list any medications or supplements your child took this week: _____

_____