

**PEDIATRIC HEALTH
ASSESSMENT FORM
4 AND 5 YEARS**

CHILD'S NAME: _____ AGE: _____ DATE: _____
 ALL MEDICATIONS: _____ ALLERGIES: _____
 ALL MEDICAL PROBLEMS: _____

PRESENT CONCERNS/PROBLEMS: _____

ACCOMPANIED BY: _____ RELATIONSHIP: _____

DAILY LIVING: (FILLED OUT BY PARENT OR GUARDIAN)

DIET: circle type MILK – WHOLE, 2%, 1%, SKIM (HOW MANY SERVINGS/DAY) _____
 DAIRY OTHER THAN MILK-CHEESE, YOGURT(SERVINGS/DAY) _____
 MEALS (SERVINGS/DAY) CEREAL/BREAD/GRAIN _____ FRUIT _____ VEGS _____ MEAT/PROTEIN _____
 JUICES (CUPS/DAY) _____ SNACKS(HOW MANY/WHAT KIND?) _____
 WATER (CUPS/DAY) _____ CIRCLE: CITY/WELL WHAT OTHER DRINKS (CUPS/DAY) _____
 HOW OFTEN DOES CHILD EAT OUT? _____(TIMES/WEEK)

- Circle which ones VITAMINS/FLUORIDE/IRON..... NO YES
- ANY ACCESS TO WEAPONS?..... NO YES
- ANY SIBLING RIVALRY OR JEALOUSY?..... NO YES
- ANY STRESSFUL SITUATIONS IN THE HOUSEHOLD? describe briefly..... NO YES
- DO PARENTS OR CAREGIVERS EVER SMOKE?..... NO YES
- ANY EXPOSURE TO ANYONE WITH TB OR WITH HIGH RISK (BORN OR LIVED OUTSIDE THE UNITED STATES, HOMELESS, INCARCERATED, HIV/DRUG USE)? NO YES
- ANY RELATIVES WITH HEART DISEASE OR HIGH CHOLESTEROL BEFORE AGE 55? NO YES
- IS CAR SEAT OR BOOSTER SEAT USED ALL THE TIME?..... NO YES
- HAVE SMOKE ALARMS?..... NO YES
- HOUSE BUILT BEFORE 1980, OR LOCATED NEAR LEAD-RELATED INDUSTRIES?..... NO YES
- HOUSEHOLD MEMBER/CLOSE CONTACT WITH HIGH LEAD WORK/HOBBY EXPOSURE?... NO YES
- OTHER LEAD EXPOSURE (I.E.: EATS NON-FOOD ITEMS / PICA; USE ANTIQUE DISHES, ETC; USE PRODUCTS FROM OTHER COUNTRIES SUCH AS HEALTH REMEDIES, ETC.)..... NO YES
- TOILET HABITS (DRY AT NIGHT? (NO/YES) SOILS PANTS OR ACCIDENTS DURING DAY? (NO/ YES) CONSTIPATION OR HARD STOOLS? (NO/YES) HAS A BOWEL MOVEMENT EVERYDAY? (NO/YES)

DESCRIBE MOST COMMON ACTIVITY? Circle which one quiet inactive /plays outside active /tv video games
 DESCRIBE PERSONALITY: _____ ANY BEHAVIOR PROBLEMS? _____
 DESCRIBE SLEEP HABITS (HOURS/24 HOURS): _____ SLEEPS IN OWN BED? Y/N _____

DESCRIBE WORK/DAY CARE SITUATION: _____
 WHO LIVES AT HOME? _____
 LAST DENTAL EXAM? _____

DEVELOPMENT: (FILLED OUT FOR THE APPROPRIATE AGE BY PARENT OR GUARDIAN)

4 YEARS OLD	NO	YES	5 YEARS OLD	NO	YES
ALTERNATES FEET GOING DOWN STAIRS?.....	<input type="checkbox"/>	<input type="checkbox"/>	ABLE TO DIAL 911?.....	<input type="checkbox"/>	<input type="checkbox"/>
BRUSHES HIS/HER OWN TEETH DAILY?.....	<input type="checkbox"/>	<input type="checkbox"/>	CATCHES/THROWS BALL (HANDS ONLY?).....	<input type="checkbox"/>	<input type="checkbox"/>
CORRECTLY TELLS THEIR AGE?.....	<input type="checkbox"/>	<input type="checkbox"/>	COUNTS 10 OR MORE OBJECTS?.....	<input type="checkbox"/>	<input type="checkbox"/>
GIVES HIS/HER FIRST AND LAST NAME?.....	<input type="checkbox"/>	<input type="checkbox"/>	DRESSES AND UNDRESSES THEMSELVES?.....	<input type="checkbox"/>	<input type="checkbox"/>
HELPFUL AROUND THE HOUSE?.....	<input type="checkbox"/>	<input type="checkbox"/>	KNOWS THEIR OWN ADDRESS AND PHONE#.....	<input type="checkbox"/>	<input type="checkbox"/>
HOPS ON ONE FOOT?.....	<input type="checkbox"/>	<input type="checkbox"/>	KNOWS HIS/HER AGE?.....	<input type="checkbox"/>	<input type="checkbox"/>
KNOWS SOME LETTERS/NUMBERS?.....	<input type="checkbox"/>	<input type="checkbox"/>	KNOWS MONTH OF THEIR BIRTHDAY?.....	<input type="checkbox"/>	<input type="checkbox"/>
TELLS ORGANIZED STORIES CLEARLY?.....	<input type="checkbox"/>	<input type="checkbox"/>	KNOWS RIGHT FROM LEFT?.....	<input type="checkbox"/>	<input type="checkbox"/>
WASHES AND DRIES HIS/HER OWN HANDS?.....	<input type="checkbox"/>	<input type="checkbox"/>	KNOWS COLORS?.....	<input type="checkbox"/>	<input type="checkbox"/>
RIDES BICYCLE?.....	<input type="checkbox"/>	<input type="checkbox"/>	PRINTS HIS/HER FIRST NAME?.....	<input type="checkbox"/>	<input type="checkbox"/>
DRAWS/SCRIBBLES?.....	<input type="checkbox"/>	<input type="checkbox"/>	SKIPS WITH FEET ALTERNATING?.....	<input type="checkbox"/>	<input type="checkbox"/>
VISION AND HEARING NORMAL?.....	<input type="checkbox"/>	<input type="checkbox"/>	KICKS BALL?.....	<input type="checkbox"/>	<input type="checkbox"/>
			TIES HIS/HER SHOE LACES?.....	<input type="checkbox"/>	<input type="checkbox"/>
			VISION AND HEARING NORMAL?.....	<input type="checkbox"/>	<input type="checkbox"/>