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
ALTERNATES FEET GOING DOWN STAIRS?………	☐	☐
BRUSHES HIS/HER OWN TEETH DAILY?…………	☐	☐
CORRECTLY TELLS THEIR AGE?…………	☐	☐
GIVES HIS/HER FIRST AND LAST NAME?…………	☐	☐
HELPFUL AROUND THE HOUSE?…………	☐	☐
HOPS ON ONE FOOT?…………	☐	☐
KNOWS SOME LETTERS/NUMBERS?…………	☐	☐
TELLS ORGANIZED STORIES CLEARLY?…………	☐	☐
WASHES AND DRIES HIS/HER OWN HANDS?…….	☐	☐
RIDES BICYCLE?…………	☐	☐
DRAWS/SCRIBBLES?…………	☐	☐
VISION AND HEARING NORMAL?…………	☐	☐

5 YEARS OLD	NO	YES
ABLE TO DIAL 911?…………	☐	☐
CATCHES/THROWS BALL (HANDS ONLY?)…………	☐	☐
COUNTS 10 OR MORE OBJECTS?…………	☐	☐
DRESSES AND UNDRESSES THEMSELVES?…………	☐	☐
KNOWS THEIR OWN ADDRESS AND PHONE#…………	☐	☐
KNOWS HIS/HER AGE?…………	☐	☐
KNOWS MONTH OF THEIR BIRTHDAY?…………	☐	☐
KNOWS RIGHT FROM LEFT?…………	☐	☐
KNOWS COLORS?…………	☐	☐
PRINTS HIS/HER FIRST NAME?…………	☐	☐
SKIPS WITH FEET ALTERNATING?…………	☐	☐
KICKS BALL?…………	☐	☐
TIES HIS/HER SHOE LACES?…………	☐	☐
VISION AND HEARING NORMAL?…………	☐	☐