Metropolitan Pediatrics

Well Child Health Screen: 5-6 Years

Name: _____ **Birthdate**: _____ **Visit Date:**_____

General Health Updates

Who is completing this form?	☐ Mom ☐ Dad ☐ Other, please list:
Any questions, concerns, or problems you want to discuss today?	
Any updates to the patient's health? (i.e. new conditions, surgeries, etc.)	
Any family health, family status or social updates we should be aware of?	
Any concerns about development, learning or behavior?	
Who lives with the patient?	
Any smoke or e-cigarette exposure?	
Anything else you want to share? (milestones, proud moments, etc.)	

Development

The following section is used to make sure they are developing normally. Each set of milestones is generally achievable by 75% of children of the same age. If you have questions/concerns, please talk to your provider.

If they are nearest **5 years**, check the items they can do most of the time:	☐ Listens well and follows simple directions ☐ Follows rules or takes turns when playing games with other children ☐ Does simple chores at home, like matching socks or clearing the table after eating ☐ Keeps a conversation going with more than three back-and-forth exchanges ☐ Counts to 10 ☐ Uses words about time, like "yesterday," "tomorrow," "morning," or "night"	☐ Pays attention for 5 to 10 minutes during activities. For example, during story time or making arts and crafts (screen time does not count) ☐ Writes some letters in their name ☐ Names some letters when you point to them ☐ Buttons some buttons ☐ Hops on one foot
If they are nearest **6 years**, check the items they can do most of the time:	☐ Skips ☐ Listens well and follows simple directions ☐ Copies squares, triangles ☐ Writes some letters and numbers ☐ Can recite alphabet	☐ Can catch a small ball (like a tennis ball) using only hands ☐ Can balance on one foot for 10 seconds or more given three chances ☐ Can say their first/last name ☐ Knows phone number/address

Health Risk Screening

The following questions may prompt your provider to complete further testing, depending on the answer. Ask your provider if you have any questions about these health screening questions.

Have they seen an eye doctor in the last year?	☐ Yes	☐ No	
Do you have concerns about their hearing?	☐ Yes	☐ No	
Do you have any concerns about low iron levels or anemia?	☐ Yes	☐ No	
Does the patient have a parent with elevated blood cholesterol level (≥240 mg/dL) or who is taking cholesterol medication?	☐ Yes	☐ No	☐ Unknown

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Family Life

Are there barriers that prevent you from spending time each day interacting with them?	☐ Yes	☐ No	
Does anyone in the home/family have problems with drugs or alcohol?	☐ Yes	☐ No	☐ Decline

Nutrition

Do you have concerns or questions about what or how they are eating?	☐ Yes	☐ No		
Do you eat together as a family?	☐ Always	☐ Sometimes	☐ Never	
Do they drink juice?	☐ Yes	☐ No		
How often do they drink caffeine, soda or other sugary drinks?	☐ Daily	☐ Weekly	☐ Rarely	☐ Never

Oral Health

Does anyone in the house have current dental decay/cavities?	☐ Yes	☐ No	☐ Unknown
Do they take extra fluoride OR drink water that contains fluoride?	☐ Yes	☐ No	☐ Unknown
Do they brush their teeth twice a day?	☐ Yes	☐ No	
Are you interested in having fluoride varnish applied during this visit?	☐ Yes	☐ No	☐ Maybe
Have they been to a dentist in the last 6 months?	☐ Yes	☐ No	

Sleep

Healthy sleep is important for growth, development, and learning. Infants and toddlers may sleep 15-18 hours in a day, while school-aged children should be getting more than 10 hours a day. We do not recommend having a screen in their bedroom as this can affect sleep.

Do you have any concerns about the amount or quality of their sleep?	☐ Yes	☐ No

Activity & Screen Time

Is the patient vigorously active for at least one hour a day?	☐ Yes	☐ No
Does the patient spend more than two hours a day in front of a screen that is not related to schoolwork?	☐ Yes	☐ No

School

Learning and socialization are a critical part of development and the skills learned there will continue to be used throughout their life. Talk to your provider if you have any specific concerns, make sure to mention if the patient is on an IEP or has a 504 for extra support.

What grade are they in and what school do they attend?			
Do they enjoy school?	☐ Yes	☐ No	
Do you have any concerns about their relationships and involvement at school?	☐ Yes	☐ No	
Do they have any learning difficulties at school (such as poor grades or support already in place like tutoring, an IEP or 504)?	☐ Yes	☐ No	

Safety

Do you have any questions about what to do when they outgrow their current car safety seat?	☐ Yes	☐ No	
Do you use sunscreen regularly?	☐ Yes	☐ No	
Do you have questions about how to keep them safe around water?	☐ Yes	☐ No	
Do they wear a helmet every time they ride a bike, scooter, skateboard, ski/snowboard?	☐ Yes	☐ No	
Have you taught them how to behave safely around pets and animals?	☐ Yes	☐ No	
If you have guns in your home, are they stored safely (locked with ammunition stored separately)?	☐ Yes	☐ No	☐ Don't have guns
Have you talked to them about what to do if they encounter a gun?	☐ Yes	☐ No	
Have you talked to them about personal boundaries and asked them to come to you if something inappropriate happens?	☐ Yes	☐ No	