

Your Child's 5 Year Well Visit – What to Expect, What to Ask

Your Name: _____ Your Relationship to the Child: _____
 Are there specific concerns you want to discuss today? No Yes _____

Have there been any major changes in your family lately? None Move Job Change Separation Divorce
 Death in the family New pet Other? Describe: _____

Child lives with? Both Parents Mother Father Stepparent Grandparent(s) Other? _____
 Total number of adults living in home: _____ Total number of children living in home: _____

Who takes care of your child most days of the week?
 Mother Father Other relative (e.g. grandmother) Daycare Other? Describe: _____

In general, how well do you feel you are coping with the day-to-day demands of parenthood?
 Not well at all Not very well Somewhat well Well Very well

General Health Information: Since Your Last Visit	Yes	No	Unsure
Have you or your child had any major illness and/or hospitalizations?			
Have you, anyone in your family, or your child's relatives developed new medical problems?			
Does your child have allergies? If yes, describe:			
Does your child take medications regularly? If yes, list here:			
Do you have someone you can trust and go to for emotional support?			
Are yours and your child's immunizations (includes flu and pneumonia vaccines) current?			
Do you or any adults around your child smoke (includes inside or outside the house)?			

Would you like to get more information on any of the topics below?

Injury Prevention	Health Promotion	Behavior	Nutrition
<ul style="list-style-type: none"> • Car safety restraints • Poisoning • Fire safety • Firearms • Street, water, bicycle safety • Scissors/sharp objects • Stranger/Self safety 	<ul style="list-style-type: none"> • Immunizations • Well-child care • Dental care, appointment • Family Planning • Daycare • Passive Smoking • Development Guide Referral 	<ul style="list-style-type: none"> • Talk/read with child • Exploration • Limit TV • Discipline, consistency • Toilet training • Social interaction • School readiness • Sex education • Teach telephone no. & address 	<ul style="list-style-type: none"> • Healthy diet/snacks • Junk Food • Iron-rich foods • Healthy weight

Do you have any specific concerns about your child's learning, development or behavior? A lot A little Not at all
 Describe: _____

Do you have any concerns about your child's vision (how well your child sees)? Yes No

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

Please check each task your child is able to do right now.

Hops, swings, climbs Speaks sentences of more than 5 words Prints some letters Count 10 or more objects

What to expect at your Child's Texas Health Steps exam

- Height & Weight Dental Referral Blood Pressure Vision & Hearing Screening Unclothed Physical Exam; Health History
- Lab tests – blood questions Immunizations (possibly DTaP, Polio, MMR, Varicella, Hepatitis A, Pneumococcal, Meningococcal & Influenza)

This is not a self-diagnosis tool or a treatment plan. Please consult your doctor and share this form at your next visit.