

Four Seasons Pediatrics
Well Visit Form for 4 Year & 5 Year Well Visit

Child's Name: _____ Birth Date: _____ Age: _____
Today's Date: _____

Any change in address, if so list new information:

School Readiness – please check off all that are true:

- Pays good attention when you read a story
- Plays quietly by him/herself for over one-half hour
- Dresses self
- Speech is understandable to others
- Does not object if left with a sitter
- Has no issues with soiling him/herself

Behavior – please check off all that are true:

- Has a good appetite
- Gets along with children of his/her age
- No problems with sleeping
- No issues with bad behavior that needs to change
- Does not have to be spanked frequently
- No serious family problems

Illnesses:

If your child is on medicines, name them: _____

Has your child had any serious illnesses since the last check up? _____

Other issues – please check off all that are true:

- Both parents are living at home
- Brushes his/her teeth daily
- Taking fluoride

Screening – Please check the box if any of the following are true:

- My child has had exposure to tuberculosis or a person with a positive skin test
- My child spends a significant amount of time in a home built before 1960
- There is a family history of high cholesterol of > 240 in either parent or grandparents
- There is a family history of heart disease before 55 in either parent or grandparents