Four Seasons Pediatrics

Well Visit Form for 4 Year & 5 Year Well Visit

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

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
[ ] Concerns with family mental health, substance abuse or firearms in the home

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

Vaccine Information Statements (Check One)

[ ] I will review the in-room copy
[ ] I will review the on-line copy at your website
[ ] I would like a paper copy

Will your child be starting Kindergarten in the next school year? Please ask for a school form if so.

School District: _____

[ ] Are there any concerns with barriers to understanding healthcare information?
[ ] Are there any concerns with the family meeting its daily needs, paying for medications, crime or violence in the area or household income?