Physicians at Sugar Creek
An Affiliate of MEMORIAL HERMANN

14023 Southwest Freeway
Sugar Land, TX 77479
218.325.4100

5 Year Well Child Exam Form

HEALTH HISTORY

Do you have any questions or concerns about your child's health that you would like to discuss today?

_____

_____

_____

What is your child's health Status? **Good Fair Poor**

Has your child been to the emergency room in the past 12 months: **Yes No**

If yes, list why: _____

Has your child been treated in the hospital in the past 12 months? **Yes No**

If yes, list why: _____

Has your child ever had any reactions to vaccines / immunizations: **Yes No**

Has your child seen a dentist in the last 6 months: **Yes No**

How many times a day does your child brush their teeth? ___ How many times a day do they floss? ___

HOME and FAMILY

Who does the child live with: _____ How many brothers and sisters does he/she have? _____

What do you live in? _____ How many bedrooms are in your home? _____

Does your child share a bedroom: **Yes No** Does anyone in the home smoke? **Yes No**

Is your child's Father Involved in his/her care? **Yes No**

How is your child's relationship with his brothers and/or sisters? **Good Fair Poor N/A, only child**

What type of discipline is used in the home: **Verbal Time-out Spanking Other: _____**

Is there any history of abuse: **Yes No** Is there any history of neglect? **Yes No**

Does anyone in home use drugs: **Yes No** Is there a history of domestic violence? **Yes No**

Has CPS ever been to your home? **Yes No** If yes, is your CPS case still open? **Yes No**

Has your child ever been in foster care? **Yes No** If yes, how many times? _____

Are you feeling stressed? **Yes No**

Do you have pets in the home: **Yes No** If yes, what type? _____

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GENERAL HEALTH

Does your child eat from all four food groups including fruit and vegetables? **Yes No**

What type of milk does he/she drink? **Whole 2% 1% Fat free Lactose free Soy**

What else does he/she drink and how many glasses a day does he/she drink? **___ Glasses of juice**

___ Glasses of water ___ glasses of caffeinated soda or tea ___ glasses of decaffeinated soda or tea

Does your child have any problems using the bathroom? (bowel movements or urinating) **Yes No**

Is he/she toilet trained? **Yes No In process**

Does he/she have any problems sleeping? **Yes No** If yes, what kind of problems? _____

Check Activities he/she participates in: ☐ Outdoor play ☐ Likes to be read to ☐ Playgroup

How many hours a day does your child watch TV?_____

Does he/she play on a computer at home: **Yes No** Or video games at home? **Yes No**

Does your child have friends? **Yes No** If yes, **many friends** or **just a few** ?

Does your child attend school? **Yes No**

If in school, does your child's teacher have any concerns? **Yes No**

Type of school: **Daycare Pre-K Head Start Early Childhood Intervention**

How is your child's performance in school? **Good Fair Poor**

What type of child care does your child have? (circle all that apply) **At home with parent/guardian**

stays with a : relative babysitter daycare early intervention

Do you have any concerns about:

Your child's development? **Yes No**

Your child's behavior? **Yes No**

Your child's hearing? **Yes No**

Your child's vision? **Yes No**

Check off each task that your child is able to do:

☐ Balances 4-5 seconds	☐ Copies square	☐ Counts 5 blocks
☐ Heel-Toe walk	☐ Draws person - 6 parts	☐ Names 4 colors
☐ Hops	☐ Brushes teeth – no help	☐ Knows 3 adjectives
☐ Catches bounced ball	☐ Dresses self – no help	☐ Knows 4 actions
☐ Copies circle	☐ Speaks fluent sentences	☐ Knows what things are

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made of

- ☐ Knows 2-3 opposites
- ☐ Prepares cereal
- ☐ Follows rules
- ☐ Toilets alone
- ☐ Plays in a group
- ☐ Separates easily from parents

GENERAL SAFETY

Does your child always use: **car seat** **booster seat**

Do you have these things in your home:

Smoke detector	**Yes**	**No**
Carbon monoxide detector	**Yes**	**No**
Fire extinguisher	**Yes**	**No**

FAMILY HISTORY:

Is there any history in the child's family of:

Heart disease	**Yes**	**No**
High Cholesterol	**Yes**	**No**
Overweight or Obesity	**Yes**	**No**

TUBERCULOSIS RISK ASSESSMENT:

1. Has your child been tested for TB? **Yes** **NO** **Do Not Know**
   If yes, when? _____
2. Has your child ever had a positive tuberculin skin test (TST)? **Yes** **NO** **Do Not Know**
   If yes, when? _____
3. TB can cause fever that can last days or weeks. It can cause weight loss, a bad cough (lasting over two weeks), or coughing up blood.
   a. Has your child been around anyone with any of these problems? **Yes** **NO** **Do Not Know**
   b. Has your child been around anyone sick with TB? **Yes** **NO** **Do Not Know**
   c. Has your child ever had any of these problems or do they have them now? **Yes** **NO** **Do Not Know**
4. Was your child born in another part of the world like Mexico or Latin America, the Caribbean, Africa, Eastern Europe, or Asia? **Yes** **NO** **Do Not Know**
5. Has your child been to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than 3 weeks? **Yes** **NO** **Do Not Know**
   Which country or countries did your child visit?_____
6. Do you know if your child has spent more than 3 weeks with anyone who:

Uses needles for drug use? Has AIDS?	**Yes**	**NO**	**Do Not Know**
Was or is in jail or prison?	**Yes**	**NO**	**Do Not Know**
Has just come to the United States from another country?	**Yes**	**NO**	**Do Not Know**