Pediatric Health Maintenance: 5 Years
Parent Questionnaire

Virginia Mason

Patient Information	
First & Last Name:	
Preferred Name:	
Date of Birth:	

General Health		☐ I'd like to discuss
☐ Yes	☐ No	Does your child seem to hear well?
☐ Yes	☐ No	Does your child seem to see well without squinting?
☐ Yes	☐ No	Do your child's eyes ever appear to cross or drift apart?
☐ Yes	☐ No	Does your child snore most nights?
☐ Yes	☐ No	Is your child in daycare, preschool, or kindergarten?
☐ Yes	☐ No	Does your child watch TV or play on a computer more than 1 hour per day?

Diet, Sleep, & Elimination		☐ I'd like to discuss
What type of milk does your child drink? ☐ Whole ☐ 1-2% ☐ Skim ☐ Other		
How much milk does your child drink each day?		
☐ Yes	☐ No	Are you concerned about your child's weight or eating habits?
☐ Yes	☐ No	Does your child eat a good variety of foods (meat, vegetables, grains, and fruit)?
☐ Yes	☐ No	Does your child have daytime accidents (bowel or bladder)?
☐ Yes	☐ No	Does your child wet the bed?

Development		☐ I'd like to discuss
☐ Yes	☐ No	Can your child run, ump, hop, and skip?
☐ Yes	☐ No	Does your child get dressed without help?
☐ Yes	☐ No	Does your child have a best friend?
☐ Yes	☐ No	Does your child know his or her own telephone number?
☐ Yes	☐ No	Can your child draw a picture of a person?
☐ Yes	☐ No	Is your child learning the alphabet?
☐ Yes	☐ No	Do you have any concerns about your child's readiness for kindergarten?

Safety		☐ I'd like to discuss
☐ Yes	☐ No	Do your children know how to get out of your home in the event of a fire?
☐ Yes	☐ No	Does your child use a helmet while biking, skating, or scootering?
☐ Yes	☐ No	Does your child ride in a booster seat in the back seat?
☐ Yes	☐ No	Are there any smokers in your home?
☐ Yes	☐ No	Are you afraid of your partner or anyone close to you?
☐ Yes	☐ No	Do you feel overly stressed or unsupported?

Specific Concerns/ Questions for Visit

☐ By typing my name in the box below, I understand that I am providing a binding electronic signature to the Well Visit 5 Years form.

Completed by (name and relationship to patient)

Date (month/day/year)

PATIENT NAME & ID #