PEDIATRIC HEALTH MAINTENANCE – 5 Years
Parent Questionnaire

General

Do you have any concerns or worries about your child or your child's development? _____ No _____ Yes

If yes, please specify: _____

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?	_____	No	_____	Yes
Does your child snore most nights?	_____	No	_____	Yes
Is your child in daycare, preschool, or kindergarten?	_____	No	_____	Yes
Does your child watch TV or play on a computer more than 1 hour per day?	_____	No	_____	Yes

Diet and Elimination

What type of milk does your child drink? _____

How much milk does your child drink each day? _____

Are you concerned about your child's weight or eating habits?	_____	No	_____	Yes
Does your child eat a good variety of foods (meat/protein, vegetables, grains, fruit)?	_____	Yes	_____	No
Does your child have daytime accidents (bowel or bladder)?	_____	No	_____	Yes
Does your child wet the bed?	_____	No	_____	Yes

Development

Can your child run, jump, 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?	_____	No	_____	Yes

Safety

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?	_____	No	_____	Yes
Does your child ride in a car seat or booster seat in the back seat?	_____	No	_____	Yes
Are there any smokers in your home?	_____	Yes	_____	No
Are you afraid of your partner or anyone close to you?	_____	No	_____	Yes
Do you feel overly stressed or unsupported?	_____	No	_____	Yes

_____ _____

Completed by (name and relationship to patient) Date (month/day/year)

PATIENT NAME