California Pediatrics
Come grow with us

5-9 Year Well Exam

Name
Room
Notes

Weight	T	HCT				
Height	HR	Vision		L	R	OU
BP	RR	Hearing		L	R	
	O2					

Nutrition					
Does your child eat 3 meals per day?	Yes	No			
Does your child consume 3-4 portions of calcium per day?	Yes	No			
Does your child get exercise everyday?	Yes	No	Example?		
Dental					
Does your child brush and floss twice daily?	Yes	No			
Does your child see a dentist twice per year?	Yes	No			
Sleep					
Does your child sleep 10 hours per night?	Yes	No			
Does your child snore?	No	Yes	Pauses?	No	Yes
Development					
What grade is your child in?					
Does your child receive any special services at school?	No	Yes			
Do you have any concerns about your child's school performance?	No	Yes			
Is it easy for your child to make friends and keep friends?	Yes	No			
Does your child wet the bed?	No	Yes			
Safety					
Do you have the number to Poison Control?	Yes	No			
Does your child use a booster seat (<8YO) or a seatbelt (>8YO)?	Yes	No			
Does your child use a helmet?	Yes	No			
Any smokers at home?	No	Yes			
Does your child live in or visit a home with a pool?	No	Yes			
Does your child live in or visit a home with a gun?	No	Yes			
Risk Assessment					
Has your child traveled outside of the U.S. in the last 6 months?	No	Yes			
Exposure to anyone with a positive TB skin test?	No	Yes			

Followup D/W/M
Reason:

□EHR