MUNDELEIN PEDIATRICS

4-6 Year Well Exam

Name: ____DOB: ____/____/____ Today's Date: ____/____/____

Please circle the answer that most appropriately describes your child:

1. Sleeps through the night: Yes/No Concerns: ___________________________
   (____) hours per night
   (____) hours from naps during the day
2. Good eating habits: Yes/No Concerns: ___________________________
3. Urinating well: Yes/No Concerns: ___________________________
4. Normal bowel movements Yes/No Concerns: ___________________________
5. Takes Vitamins: Yes/No Product Name: _______________________
6. Emergency room visits: Yes/No
7. Illness since last visit: ____
8. Grade level in school: __________; Concerns with school performance__________________________
9. Developmentally: dresses without supervision, role playing, goes to the bathroom alone, counts 4 objects accurately, tells a story, writes name, can recite alphabet, rides 2-wheeler with training wheels, hops on one foot, uses scissors to cut pictures, climbs well

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Please circle the answer that most appropriately describes your home environment:

1. Smoke-free home and car: Yes/No
2. Parent smokes outside: Yes/No Mom/Dad/Sibling/Relative/Babysitter
3. Fire arms at home: Yes/No If yes, are safety precaution taken: Yes/No
4. Television /Video game time: Hours per day: ______________________________
5. Rides in a booster seat in the back seat: Yes/No
6. Uses helmet when riding bike, skates and scooters Yes/No
7. Daycare: None/Relative/Center/Babysitter
8. Primary care taker: Mom/Dad/Grandparents
9. Household composition:
   Adult(Names/Ages): ____

   Children(Names/Ages): ____

10. New health problems in parents or siblings: ____
11. Dental Visits Yes/No
12. Past vaccine reactions: Yes/No
13. Sibling rivalry: Yes/No

Do you have any other concerns you wish to discuss? Yes/No

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