To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

**WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?**

Do you have any concerns, questions, or problems that you would like to discuss today?  ○ No  ○ Yes, describe:

**TELL US ABOUT YOUR CHILD AND FAMILY.**

What excites or delights you most about your child?

Does your child have special health care needs?  ○ No  ○ Yes, describe:

Have there been major changes lately in your child's or family's life?  ○ No  ○ Yes, describe:

Have any of your child's relatives developed new medical problems since your last visit?  ○ No  ○ Yes  ○ Unsure  If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes?  ○ No  ○ Yes  ○ Unsure

**YOUR GROWING AND DEVELOPING CHILD**

Do you have specific concerns about your child’s development, learning, or behavior?  ○ No  ○ Yes, describe:

Check off each of the tasks that your child is able to do.

- Is beginning to skip.
- Walk on tiptoes when asked.
- Catch a bounced ball with 2 hands.
- Copy a triangle.
- Draw a 6-part person.
- Copy first name.
- Cut well with scissors.
- Spread with a knife.
- Dress and undress without help.
- Urinate and have a bowel movement on her own.
- Is dry through the day.
- Tell a story of 2 sentences or more.
- Follow directions for 4 individual prepositions, such as on, under, behind, and in front of.
- Play and interact with peers.
- Answer “why” questions.
- Count 5 objects.
- Name 3 or more single numbers.
- Name 4 or more letters out of alphabetic order.
- Write 2 or more letters.
## RISK ASSESSMENT

<table>
<thead>
<tr>
<th>Condition</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>Does your child’s diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do you ever struggle to put food on the table?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead</td>
<td>Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or was renovated in the past 6 months?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral health</td>
<td>Does your child have a dentist?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does your child’s primary water source contain fluoride?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is your child infected with HIV?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## ANTICIPATORY GUIDANCE

### How are things going for you, your child, and your family?

#### YOUR FAMILY’S HEALTH AND WELL-BEING

**Neighborhood and Family Violence (Bullying and Fighting)**
- Are there frequent reports of violence in your community or school? [ ] No [ ] Yes
- Has your child ever been bullied or hurt physically by someone? [ ] No [ ] Yes
- Has your child ever bullied or been aggressive with others? [ ] No [ ] Yes

**Food Security**
- Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more? [ ] No [ ] Yes
- Within the past 12 months, did the food you bought not last, and you did not have money to get more? [ ] No [ ] Yes

**Alcohol and Drugs**
- Is there anyone in your child’s life whose alcohol or drug use concerns you? [ ] No [ ] Yes

**Emotional Security and Self-Esteem**
- Does your child usually seem happy? [ ] Yes [ ] No
- Are there things your child is really good at doing or is proud of? [ ] Yes [ ] No

**Connectedness With Family**
- Does your family get along well with each other? [ ] Yes [ ] No
- Does your family do things together? [ ] Yes [ ] No

#### FAMILY RULES AND ROUTINES

- Does your child have chores or responsibilities at home? [ ] Yes [ ] No
- Do you have clear rules and expectations for your child? [ ] Yes [ ] No
- When your child breaks the rules, are you consistent with consequences and discipline? [ ] Yes [ ] No
- Do you let your child know when she is being good? [ ] Yes [ ] No
- Does your child have problems dealing with angry feelings? [ ] No [ ] Yes
- Do you help your child control his anger? [ ] Yes [ ] No

#### SCHOOL

- Did your child attend a preschool program? [ ] Yes [ ] No
- Has your child started elementary school? [ ] Yes [ ] No
- Do you have any concerns about your child’s school experience? [ ] NA [ ] No [ ] Yes
### 5 YEAR VISIT

#### SCHOOL (CONTINUED)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you able to attend activities or functions at your child’s school?</td>
<td></td>
<td></td>
<td>O</td>
</tr>
<tr>
<td>Is your child involved in after-school activities?</td>
<td></td>
<td></td>
<td>O</td>
</tr>
<tr>
<td>Does your child receive any special education services?</td>
<td>O</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

#### STAYING HEALTHY

**Healthy Teeth**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child brush his teeth twice a day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child see the dentist twice a year?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Nutrition**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any concerns about your child’s eating? This includes drinking enough milk and eating vegetables and fruits.</td>
<td>O</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Does your child drink soda, juice, or other sugar-sweetened drinks?</td>
<td>O</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Does your child eat breakfast every day?</td>
<td>O</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

**Physical Activity**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your child physically active at least 1 hour every day? This includes running, playing sports, or active play with friends.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much time every day does your child spend watching TV or using computers, tablets, or smartphones (not counting schoolwork)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child have a TV or an Internet-connected device in his bedroom?</td>
<td>O</td>
<td>No</td>
</tr>
<tr>
<td>Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?</td>
<td>O</td>
<td>No</td>
</tr>
<tr>
<td>Does your child have trouble going to sleep or does he wake up during the night?</td>
<td>O</td>
<td>No</td>
</tr>
<tr>
<td>Does your child have a regular bedtime?</td>
<td>O</td>
<td>No</td>
</tr>
</tbody>
</table>

#### SAFETY

**Car Safety**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your child fastened securely in a car safety seat or belt-positioning booster seat in the back seat every time he rides in a vehicle?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does everyone else in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?</td>
<td>O</td>
<td>No</td>
</tr>
</tbody>
</table>

**Outdoor Safety**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child always wear a helmet to protect her head when biking, skating, or doing other outdoor activities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child know street safety habits, such as stopping at the curb, looking both ways, and never crossing the street without a grown-up?</td>
<td>O</td>
<td>No</td>
</tr>
<tr>
<td>Does your child know how to swim?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child know to always have an adult watching her in the water and never to swim alone?</td>
<td>O</td>
<td>No</td>
</tr>
<tr>
<td>Does your child always use sunscreen when playing outside?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Home Fire Safety**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have working smoke alarms installed on every level of your home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have carbon monoxide detectors/alarms in your home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have an emergency escape plan in case of fire?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child know what to do if the fire alarm rings?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# 5 Year Visit

## Safety (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does anyone in your home or the homes where your child spends time have a gun?</td>
<td>☐  Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>If yes, is the gun unloaded and locked up?</td>
<td>☐  Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>If yes, is the ammunition stored and locked up separately from the gun?</td>
<td>☐  Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Have you talked with your child about gun safety?</td>
<td>☐  Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Have you taught your child that it is never OK for an adult to tell a child to keep secrets from her parents?</td>
<td>☐  Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Does your child know that it is never OK for an older child or an adult to ask to see his private parts?</td>
<td>☐  Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition*

For more information, go to [https://brightfutures.aap.org](https://brightfutures.aap.org).

© 2019 American Academy of Pediatrics. All rights reserved.
### Well Child | 5 Year Visit

**Name:**

**Date/Time:**

<table>
<thead>
<tr>
<th>Accompanied By:</th>
<th>Preferred Language:</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight (%)</th>
<th>Height (%)</th>
<th>BMI (%)</th>
<th>BP (%)</th>
<th>ID Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vitals (if indicated):</th>
<th>Temp:</th>
<th>HR:</th>
<th>Resp Rate:</th>
<th>SpO₂:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HISTORY**

**Concerns and Questions:** □ None

**Interval History:** □ None

**Medical History:** □ Child has special health care needs.

Areas reviewed and updated as needed

□ Past Medical History (See Initial History Questionnaire.)

□ Surgical History (See Initial History Questionnaire.)

□ Problem List (See Problem List.)

**Medications:** □ None

□ Reviewed and updated (See Medication Record.)

**Allergies:** □ No known drug allergies

**Nutrition:** □ Good appetite □ Good variety

□ Daily fruits and vegetables: __________________________

□ Iron: Source: __________________________

□ Calcium: Source: __________________________ Amount: ________

**Comments:** __________________________

**Dental Home:** □ No □ Yes: __________________________

Brushing twice daily: □ Yes □ No: __________________________

**Fluoride:** □ In water source □ Oral supplement □ Other: __________________________

Sugar-sweetened beverages: □ No □ Yes

**Elimination:** □ Regular soft stools: __________________________

**Sleep:** □ No concerns

**Physical Activity:**

Playtime (60 min/d): □ Yes □ No: __________________________

Screen time: h/d: ______

**Source:** __________________________ Quality monitored: □ Yes □ No

Family media use plan discussed: □ Yes □ No

**School:** Grade: __________________________ IEP/504/behavior plan: □ Yes □ No □ NA

Performance: □ NL __________________________

Parent/teacher concerns: □ None

**Behavior:** □ No concerns

**DEVELOPMENT**

☑ Normal development □ See Previsit Questionnaire.

Caregiver concerns about development: □ None □ Yes: __________________________

□ SOCIAL LANGUAGE AND SELF-HELP

• Spreads with a knife

• Dresses and undresses without help

• Goes to bathroom independently

• Is dry through the day

• Plays and interacts with peers

• Answers “why” questions

□ VERBAL LANGUAGE

• Tells a story of 2 sentences or more

• Follows directions for 4 individual prepositions

• Counts 5 objects

• Names 3 or more numbers

• Names 4 or more letters out of order

□ GROSS MOTOR

• Is beginning to skip

• Walks on tiptoes when asked

• Catches a bounced ball with 2 hands

□ FINE MOTOR

• Copies a triangle

• Draws a 6-part person

• Copies first name

• Cuts well with scissors

• Writes 2 or more letters

**American Academy of Pediatrics**

DE D I D E T E D  T O  T H E  H E A L T H  O F  A L L  C H I L D R E N®

American Academy of Pediatrics | Bright Futures | https://brightfutures.aap.org

© 2019 American Academy of Pediatrics. All rights reserved.
Well Child | 5 Year Visit

SOCIAL AND FAMILY HISTORY

Areas reviewed and updated as needed (See Initial History Questionnaire.): ☐ Social History ☐ Family History

Changes since last visit: _______________________ ☐ No interval change

Smoking household: ☐ No ☐ Yes: __________________________

Firearms in home: ☐ No ☐ Yes: __________________________

Observation of parent-child interaction: __________________________

Parents working outside home: ☐ One parent ☐ Both parents After-school care: __________________________

REVIEW OF SYSTEMS

☐ A 10-point review of systems was performed and results were negative except for any positive results listed below.

**Bold** = Focus area for this Bright Futures Visit

<table>
<thead>
<tr>
<th>Constitutional:</th>
<th>Respiratory:</th>
<th>Skin:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes: __________</td>
<td>Gastrointestinal:</td>
<td>Neurological:</td>
</tr>
<tr>
<td>Head, Ears, Nose, and Throat:</td>
<td>Genitourinary:</td>
<td>Other:</td>
</tr>
<tr>
<td>Cardiovascular:</td>
<td>Musculoskeletal:</td>
<td>Other:</td>
</tr>
</tbody>
</table>

PHYSICAL EXAMINATION

✓ = System examined  **Bold** = Focus area for this Bright Futures Visit

Normal examination findings in text. Cross out abnormalities. Describe other findings in the area provided.

☐ General: Well-appearing child. **Normal BMI and BP for age.**

☐ Head: Normocephalic and atraumatic.

☐ Eyes: Pupils equal, round, and reactive to light. **Extraocular eye movements intact.** Normal funduscopic examination findings.

☐ Ears, nose, **mouth**, and throat: Tympanic membranes with visible light reflex bilaterally. Healthy-appearing teeth **without visible caries.** No gingivitis. No malocclusion.

☐ Neck: Supple, with full range of motion and no significant adenopathy.

☐ Heart: Regular rate and rhythm. No murmur.

☐ Respiratory: Breath sounds clear bilaterally. Comfortable work of breathing.

☐ Abdomen: Soft, with no palpable masses.

☐ Genitourinary:

☐ Normal female external genitalia.

☐ Normal male external genitalia, with testes descended bilaterally.

☐ Musculoskeletal: Spine straight. Full range of motion.

☐ Neurological: Normal gait. Fine motor skills appropriate for age.

☐ Skin: Warm and well perfused. No rashes or bruising. No atypical nevi or birthmarks.

Other comments: __________________________

ASSESSMENT

☐ Well child ☐ Normal interval growth (See growth chart.) ☐ Normal BMI percentile for age ☐ Normal BP percentile for age

☐ Age-appropriate development
Well Child | 5 Year Visit

Name: ____________________________

**ANTICIPATORY GUIDANCE**

- **SOCIAL DETERMINANTS OF HEALTH**
  - Neighborhood and family violence
  - Food security
  - Family substance use
  - Emotional security and self-esteem
  - Connectedness with family

- **DEVELOPMENT AND MENTAL HEALTH**
  - Family rules and routines, concern for others, and respect for others
  - Patience and control over anger

- **SCHOOL**
  - Readiness, established routines, school attendance, and friends
  - After-school care and activities; parent-teacher communication

- **PHYSICAL GROWTH AND DEVELOPMENT**
  - Oral health
  - Nutrition
  - Physical activity

**PLAN**

**Immunizations:**
- Vaccine Administration Record reviewed
- Administered today: ____________________________
- Up-to-date for age

**Universal Screening:**
- **Hearing:** Result: [ ] Unable to complete [ ] Normal hearing BL [ ] Abnormal:
- **Vision:** Result: [ ] Unable to complete [ ] Normal vision for age [ ] Abnormal:
- **Oral health:** Fluoride varnish applied: [ ] Yes [ ] No: ____________
  - Oral fluoride supplementation: [ ] Yes [ ] No: ____________ [ ] NA

**Selective Screening** (based on risk assessment) (See Previsit Questionnaire):
- Anemia
- Lead
- Oral health
- Tuberculosis

Comments/results:

**Follow-up:**
- Routine follow-up at 6 years
- Next visit: ____________
- Referral to: ____________________________

**PRINT NAME**

Provider 1

Provider 2

**SIGNATURE**

Satisfied with Bright Futures: Guidelines for Health Supervision of Infants, Children, Adolescents, 4th Edition
**HOW YOUR FAMILY IS DOING**

- Spend time with your child. Hug and praise him.
- Help your child do things for himself.
- Help your child deal with conflict.
- If you are worried about your living or food situation, talk with us. Community agencies and programs such as SNAP can also provide information and assistance.
- Don’t smoke or use e-cigarettes. Keep your home and car smoke-free. Tobacco-free spaces keep children healthy.
- Don’t use alcohol or drugs. If you’re worried about a family member’s use, let us know, or reach out to local or online resources that can help.

**FAMILY RULES AND ROUTINES**

- Family routines create a sense of safety and security for your child.
- Teach your child what is right and what is wrong.
- Give your child chores to do and expect them to be done.
- Use discipline to teach, not to punish.
- Help your child deal with anger. Be a role model.
- Teach your child to walk away when she is angry and do something else to calm down, such as playing or reading.

**STAYING HEALTHY**

- Help your child brush his teeth twice a day
  - After breakfast
  - Before bed
- Use a pea-sized amount of toothpaste with fluoride.
- Help your child floss his teeth once a day.
- Your child should visit the dentist at least twice a year.
- Help your child be a healthy eater by
  - Providing healthy foods, such as vegetables, fruits, lean protein, and whole grains
  - Eating together as a family
  - Being a role model in what you eat
- Buy fat-free milk and low-fat dairy foods. Encourage 2 to 3 servings each day.
- Limit candy, soft drinks, juice, and sugary foods.
- Make sure your child is active for 1 hour or more daily.
- Don’t put a TV in your child’s bedroom.
- Consider making a family media plan. It helps you make rules for media use and balance screen time with other activities, including exercise.

**READY FOR SCHOOL**

- Talk to your child about school.
- Read books with your child about starting school.
- Take your child to see the school and meet the teacher.
- Help your child get ready to learn. Feed her a healthy breakfast and give her regular bedtimes so she gets at least 10 to 11 hours of sleep.
- Make sure your child goes to a safe place after school.
- If your child has disabilities or special health care needs, be active in the Individualized Education Program process.

**Helpful Resources:**

- Family Media Use Plan: [www.healthychildren.org/MediaUsePlan](http://www.healthychildren.org/MediaUsePlan)
- Smoking Quit Line: 800-784-8669
- Information About Car Safety Seats: [www.safercar.gov/parents](http://www.safercar.gov/parents)
- Toll-free Auto Safety Hotline: 888-327-4236
5 AND 6 YEAR VISITS—PARENT

SAFETY

- Your child should always ride in the back seat (until at least 13 years of age) and use a forward-facing car safety seat or belt-positioning booster seat.
- Teach your child how to safely cross the street and ride the school bus. Children are not ready to cross the street alone until 10 years or older.
- Provide a properly fitting helmet and safety gear for riding scooters, biking, skating, in-line skating, skiing, snowboarding, and horseback riding.
- Make sure your child learns to swim. Never let your child swim alone.
- Use a hat, sun protection clothing, and sunscreen with SPF of 15 or higher on his exposed skin. Limit time outside when the sun is strongest (11:00 am–3:00 pm).
- Teach your child about how to be safe with other adults.
  - No adult should ask a child to keep secrets from parents.
  - No adult should ask to see a child’s private parts.
  - No adult should ask a child for help with the adult’s own private parts.
- Have working smoke and carbon monoxide alarms on every floor. Test them every month and change the batteries every year. Make a family escape plan in case of fire in your home.
- If it is necessary to keep a gun in your home, store it unloaded and locked with the ammunition locked separately from the gun.
- Ask if there are guns in homes where your child plays. If so, make sure they are stored safely.

Consistent with Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition

For more information, go to https://brightfutures.aap.org.