5 YRS QUESTIONNAIRE

Date:____________

Name of Patient_________________DOB____________________

1. ☐ Whole milk ☐ 2% milk ☐ 1% milk ☐ Other________________
   How much?___oz per day
2. All food groups included in diet ☐ Y ☐ N
3. Juice_____oz per day
4. Regular bowel movements ☐ Y ☐ N
5. Has your baby been in contact with anybody who has active Tuberculosis ☐ Y ☐ N
6. Dental home is established with__________. Last check up was _________

Development:

- Any developmental concerns ☐ Y ☐ N
- Is the your child in Kindergarten ☐ Y ☐ N
- Sleep and behavior is appropriate ☐ Y ☐ N

Other
Comments:____
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