La Loma
5-Year-Old Well Child

Name:_____ DOB:_____ Age:_____

Medications:		
Is your child on any medications?	YES	NO
If Yes, Please List:		
Allergies:		
Does your child have any allergies to medications?	YES	NO
Sensory:		
Vision:		
Does your child appear to be able to see well?	YES	NO
Hearing/Speech:		
Does your child appear to be able to hear?	YES	NO
Is your child's speech understandable 100% of the time by strangers? People?	YES	NO
Development:		
Does your child dress without help?	YES	NO
Does your child know his/her address?	YES	NO
Can your child draw a person with 4 parts? (e.g. a circle with lines from it)	YES	NO
Can your child copy a triangle?	YES	NO
Can your child count on his/her fingers?		
Does your child count to ten or more?	YES	NO
Can your child recognize most letters of the alphabet?	YES	NO
Can your child play cooperatively? (e.g. simple boardgames)	YES	NO
Nutrition: Does our child overall eat well (eat a generally diverse balanced diet)?	YES	NO
Is your child on any supplements? E.g. Fluoride, Vitamins, or Iron	YES	NO

Do you have any concerns regarding your child? []NO [] YES (Explain Below)

Signed_____ Printed Name_____

Relationship to Patient? _____ Date_____

Reviewed with Above_____

La Loma Internal Medicine and Pediatrics

Child COMPREHENSIVE REVIEW OF SYSTEMS

Instructions: Answer yes if the following problems are CURRENT, FREQUENT or BOTHERSOME for your child. Explain all yes answers at the end of the last page.

GENERAL: **Date:** _____

When was your child's last physical?	Date	
Has your child had a recent UNEXPLAINED loss of weight?	YES	NO
Does your child have a fever?	YES	NO
Does your child have excessive fatigue?	YES	NO
Does your child have an acceptable appetite?	YES	NO

EARS, EYES, NOSE, THROAT:

Does your child have any drainage from eyes?	YES	NO
Does your child have any redness or irritation in eyes?	YES	NO
Does your child complain of itchy watery eyes?	YES	NO
Does your child have a sore throat?	YES	NO
Does your child have Nasal Congestion?	YES	NO
Does your child have frequent runny noses?	YES	NO
Does your child suffer from frequent bloody noses? If so, how many per week?	YES	NO
Does your child complain of sinus pressure?	YES	NO
When was your child's last eye exam?	Date	

PULMONARY/ LUNGS:

Is your child frequently short of breath? (If yes, AT REST or WITH ACTIVITY)	YES	NO
Does your child cough up sputum or mucus <u>most days?</u>	YES	NO
Does your child cough up blood?	YES	NO
Has your child had a continuous cough for longer than two to three months?	YES	NO
Does your child cough with exercise?	YES	NO
Does your child Wheeze?	YES	NO

CARDIOVASCULAR/HEART:

Does your child get chest pain often?	YES	NO
Does your child complain of a racing heart?	YES	NO
Do your child's extremities swell?	YES	NO
Does your child have trouble breathing while lying flat?	YES	NO
Does your child turn blue around the mouth or have rapid breathing during exercises?	YES	NO
Does the patient's mother or father have elevated cholesterol or heart disease?	YES	NO
Has your child ever had their cholesterol checked?	YES	NO

PATIENT NAME: _____

GASTROINTESTINAL/STOMACH, INTESTINES, LIVER GALLBLADDER:

Does your child complain OFTEN of stomach pains?	YES	NO
Does your child complain of frequent nausea?	YES	NO
Does your child have frequent vomiting?	YES	NO
Does your child have frequent diarrhea?	YES	NO
Does your child have bright red blood in stools?	YES	NO
Does your child have black tarry stools?	YES	NO
Does your child have frequent constipation?	YES	NO
Does your child have difficulty swallowing?	YES	NO

GENITOURINARY/ GENITALS, KIDNEY, BLADDER, URINATION:

Does your child often complain of burning or discomfort with urination?	YES	NO
Does your child have any blood in urine?	YES	NO
Does your child urinate more frequently than normal?	YES	NO
Does your child get up to urinate more than once per night?	YES	NO
Does your child have problems with incontinence? (uncontrolled loss of urine)?	YES	NO
Does your child have sores / lesions on genitals?	YES	NO

HEMATOLOGIC (BLOOD)

Does your child have problems with bleeding or a history of hemophilia? (Circle which one)	YES	NO
Does your child have a history of anemia?	YES	NO
Does your child have swollen glands that do not resolve?	YES	NO

ENDOCRINE (GLANDS)

Does your child have problems with excessive thirst?	YES	NO
Does your child have dry brittle hair and nails?	YES	NO

MUSCULOSKELETAL / SKIN

Does your child complain often of joint pain?	YES	NO
Does your child have joints that swell or get red? (Circle which one or both)	YES	NO
Does your child often have a rash?	YES	NO

NEUROPSYCHIATRIC (NERVES, BRAINS)

Does your child often have trouble sleeping?	YES	NO
Does your child appear depressed or often sad?	YES	NO
Does your child complain of frequent numbness of legs and feet?	YES	NO
Does your child complain of frequent weakness in extremities?	YES	NO

PATIENT NAME: _____