Review of systems for age:

5 years

Name:_______________________ Date of Birth______________

Date____________ Chart # (Office use)__________________

(Please check the statements that apply to your child.)

☐ There is smoking in our home.

☐ There is a concern about a balanced diet.

☐ There is a concern about safety inside or outside of the child's home.

☐ There is a family or marital problem.

☐ There is a concern about my child starting school.

☐ There are questions about disciplining our child.

☐ There is a problem with bed wetting.

☐ My child has had their first eye exam. If yes with Dr.________________on________________.

☐ My child has dental exams. If yes, with Dr.____________________last performed on_________________.

☐ I have questions on vitamins or fluoride.

☐ I have questions on immunizations.

☐ There are concerns that this questionnaire does not address.