Name FMP/SSN last four: DOB:

Email Address : Contact Phone Number:

2 - 5 YEAR VISIT

Do you have any specific concerns today? _____

_____

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions	Surgeries/ Hospitalizations	Dates	Family History (biological siblings, parents, grandparents) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
Hayfever/allergies **Asthma** **Premie** **Overweight** **Chronic ear infections** **Other: (reflux)**	Example circumcision		**Allergies** **Asthma** **Diabetes** **Heart Disease** **Obesity**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):** ❑ Infant Multivitamin 1 ml per day

Any hospitalizations, specialty care or ER visits since last appointment? ❑Yes ❑No Please specify _____

Check if anyone in the family has had:

□ High Blood Pressure □ Diabetes □ Heart attack < 50 years □ Sudden Death □ Mental Illness

□ High Cholesterol □ Obesity □ Genetic or Metabolic Disease □ Long QT syndrome □ Hypertrophic Cardiomyopathy

Please list any known **allergies** your child has (drug, food, latex) _____

Is your child enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? ❑ Yes ❑ No

Is the child's sponsor currently deployed? ❑ Yes ❑ No Is this visit **deployment** related? ❑ Yes ❑ No

Are your child's immunizations up to date? ❑ Yes ❑ No ❑ Unsure

Who does your child live with? _____

Does your child attend? ❑ Daycare ❑ Preschool ❑ Kindergarten ❑ Home-schooled

Does anyone in the family smoke? ❑ Yes ❑ No

Do you & your child feel safe at home? ❑ Yes ❑ No

What is your preferred method for learning: ❑ Verbal ❑ Written ❑ Visual ❑ Other: _____

Ethnic Origin ❑Filipino ❑Hispanic ❑ Asian/Pacific Islander ❑Southeast Asian ❑ Other ❑ Unknown ❑ Decline to Respond

Race ❑ Asian/Pacific Islander ❑ African American ❑ Caucasian ❑ Western Indian ❑ Other ❑ Unknown ❑ Decline to Respond

Preferred language: ❑ English ❑ Other: _____

Are there cultural or religious considerations that affect your child's healthcare? ❑ Yes ❑ No _____

Please See Reverse Side

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

STANDARD FORM 600 Overprint

Diet/Exercise History:

Current Diet Less Than **5** Servings a day Of Fruits and/or vegetables ❑ Yes ❑ No

Current Diet High in Fat Content and Includes High Fat Snacks❑ Yes ❑ No

Current Diet High Fat and includes Frequent Fast Foods ❑ Yes ❑ No

Current Diet High Fat and Includes Fried Foods ❑ Yes ❑ No

Days a Week eating Breakfast _____ Days/week Having Dinner with Family _____

Eats Extra Large Portions ❑ Yes ❑ No High Sugar Beverages ❑ Yes ❑ No How many ounces per day? _____
Caffeinated Beverages ❑ Yes ❑ No How many per week? ____

Daily Milk Intake ___ounces per day Type of milk? ❑ Whole ❑ 2% ❑ 1% ❑ Skim

My child spends ❑Less than 2hrs per day watching TV/Video Games ❑ More Than 2 hrs per day watching TV/Video Games
❑ Less than 1 hr of active play per day ❑More than 1 hour of active play per day

Concerned about Bowel Movements ❑ Yes ❑ No Constipation ❑ Yes ❑ No Currently Toilet Training ❑ Yes ❑ No

Bladder Trained ❑ Yes ❑ No Bowel Trained ❑ Yes ❑ No Sleep Disturbances ❑ Yes ❑ No

Circle if you have any concerns about the following: Bowel movements / Constipation / Sleep problems

In the past week, has your child had:

Fever	Yes/No	Duration?_____	Cough	Yes/No	Duration?_____
Headache	Yes/No	Duration?_____	Wheezing	Yes/No	Duration?_____
Congestion	Yes/No	Duration?_____	Vomiting	Yes/No	Duration?_____
Runny nose	Yes/No	Duration?_____	Diarrhea	Yes/No	Duration?_____
Earache	Yes/No	Duration?_____	Abdominal pain	Yes/No	Duration?_____
Pulling at ears	Yes/No	Duration?_____	Appetite Less	Yes/No	Duration?_____
Eye discharge	Yes/No	Duration?_____	Rash	Yes/No	Duration?_____
Sore throat	Yes/No	Duration?_____	Other (describe)_____		

If Ages & Stages Questionnaire NOT completed today, check the following that apply to your child:

24 MONTHS	30 MONTHS	36 MONTHS	4 YEARS	5 YEARS
❑ Uses 50 words or more	❑ Names an animal in a picture	❑ Knows 3 of 4 colors	❑ Can sing a song	❑ Draws a person with a head, body, arms, legs
❑ 2-3 word sentences	❑ Jumps in place	❑ Knows name/age/sex	❑ Uses prepositions	❑ Recognizes letters
❑ Turns single pages	❑ Throws ball overhand	❑ Uses pronouns	❑ Knows 3 of 4 colors	❑ Can print letters
❑ Stacks 5 or more blocks	❑ Can draw a straight line	❑ Understands cold, hungry, tired	❑ Can draw a person with 3 body parts	❑Skips
❑ Takes off their own clothes	❑ Stacks 5 or more blocks	❑ Alternates feet walking up stairs	❑ Can copy a cross	❑Balances on one foot for 5 seconds
❑ Runs well	❑ Dresses with help	❑ Balances on a foot for 1 second	❑ Buttons clothes	❑ Plays with other children
❑ Kicks a ball forward	❑ Washes and dries hands	❑ Throws a ball overhand	❑ Dresses without help	❑Copies a triangle or square
❑ Walks up stairs	❑ Plays well with other children	❑ Copies a circle	❑ Jumps on one foot	
		❑ Pretends when playing	❑ Plays make-believe	
		❑ Plays well with other children	❑ Plays well with other children	