Patient Name_____

Date of Birth _____

Risk Assessment 5 Year

Draws a person with 6 body parts	Yes	No	Comment
Copies squares, triangles	Yes	No	Comment
Writes some letters and numbers	Yes	No	Comment
Ties a knot	Yes	No	Comment
Balances on one foot	Yes	No	Comment
Hops, skips, climbs	Yes	No	Comment
Counts to 10	Yes	No	Comment
Names at least 4 colors	Yes	No	Comment
Listens well and follows simple instructions	Yes	No	Comment
Can tell a story with full sentences	Yes	No	Comment

Servings of fruit & vegetables per day	More than 4 per day	3-4 per day	1-2 per day	0-1 per day
Eats out each week	0-1 times	1-2 times	3-4 times	More than 4 times
Activity level	More than 60 min per day	30-60 min per day	Less than 30 min per day	Not very often
Sweet drinks per day	Not very often	1 per day	2 per day	More than 3 per day
TV/screen time	Not very often	30-60 min/d	1-2hr/d	More than 2hr/d

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Have any members of the family or your child's playmates had high blood lead level	No	Yes	Unknown	Comment
Does child live/visit house built before 1978 that is currently being renovated?	No	Yes	Unknown	Comment
Does child live/visit a house/apartment/building built before 1950?	No	Yes	Unknown	Comment
Born in country outside of the United States	No	Yes	Unknown	Comment
Traveled or had contact with high TB risk populations longer than a week	No	Yes	Unknown	Comment
Family member or contact had tuberculosis or positive TB skin test.	No	Yes	Unknown	Comment
Is the child HIV infected	No	Yes	Unknown	Comment

 Patient Name_____

Diet included iron-rich foods such as meat, eggs, iron fortified cereal, or beans	Yes	No	Comment
Does child go to school	Yes	No	Comment
Concerns about child doing well in school	No	Yes	Comment
Does child do simple chores around house	Yes	No	Comment
Does child get along with his/her friends	Yes	No	Comment
Does child eat breakfast everyday	Yes	No	Comment
Does child have at least 3 servings of low fat milk, cheese, or yogurt per day	Yes	No	Comment
Do you limit foods like candy, soft drinks, salty snacks and fast food	Yes	No	Comment
Concerns about child's weight	No	Yes	Concerns
Does child brush teeth twice per day	Yes	No	Comment
Does child see dentist at least twice a year	Yes	No	Comment
Always uses safety/booster seat in back seat of car or any vehicle	Yes	No	Comment
Knows street safety such as looking both ways and never crossing without a grown up	Yes	No	Comment
Wears helmet/protective gear when biking, skating, skiing, or snowboarding	Yes	Sometimes	No
Does anyone smoke around child	No	Yes	Concerns